

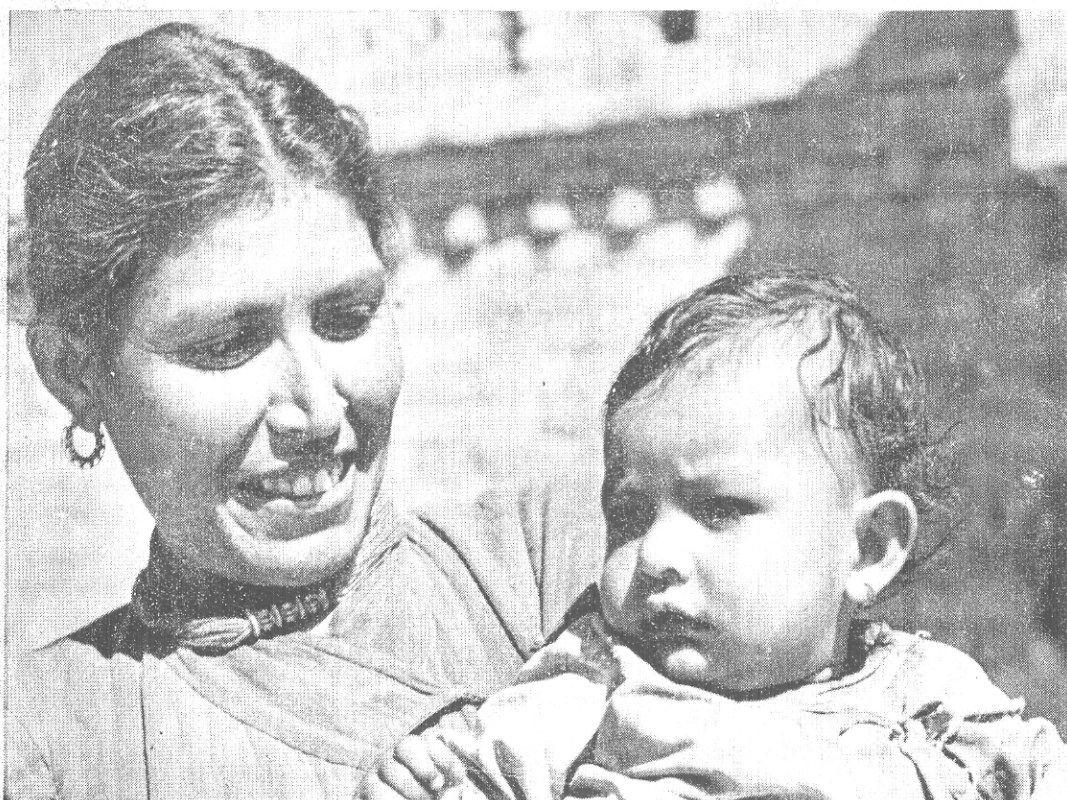


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contributions to nepalese studies



anthropology, health and development

vol. 3 special issue

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References cited and other notes should be given at the end of article and reference numbers in the text should be given in sequence.

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introduction

This number of Contributions to Nepalese Studies is the first of what is hoped to be a series of special numbers of this journal devoted to topics of interest to research workers and development planners in Nepal. In future issues, topics will be taken from linguistics, sociology, history and anthropology (the fields of focus at the Institute of Nepal and Asian Studies, Tribhuvan University), bringing together readings based on recent research and presenting new perspectives on areas of recurring interest in the development of Nepal.

Our first special number of focuses on health, but explores the question from an anthropological point of view. Five papers are presented, each with a slightly different emphasis, three are concerned primarily with the cultures of the Brahmins and Chhetris of Central Nepal. Each focuses on traditional views of health in some form. The first study, "Sex and Motherhood among the Brahmins and Chhetris of East-Central Nepal" emphasizes health in relation to sex and family planning from the point of view of women studied in a small, rural community on the edge of the Kathmandu Valley. Traditional Hindu attitudes towards fertility, and childbirth are explored, along with concepts of pre-school child development and an outline of common childhood diseases and their treatments. The second article, "Concepts of Illness and Curing/in a Central Nepal Village", takes a broader perspective. Based on work done in Nuwakot district, the author discusses local concepts of illness causation, concentrating on the cultural and psychological aspects of illness. The third study, "Levels of Medicine in a Central Nepali Village," comes from work done in Gorkha district in a community made up of Muslims as well as Chhetris. As with the preceding article, the paper is concerned with local concepts of illness and its causation. Both present analyses of the complex interaction between these traditional concepts and the new choices presented by the arrival of new techniques of medical practice brought about by the development of health delivery systems in Nepal. By presenting these concepts of illness and curing as different systems of conceptualization, not merely as competitive practices, both papers give new insight into the reasons for success or failure of certain aspects of health development.

The fourth article, "Notes on Two Shaman-Curers in Kathmandu" is the work of an anthropologist whose field here is the urban setting. Presented are the "case-books" of two Tamang shamans who practice among different ethnic groups in the Kathmandu Valley. The author records which illnesses are treated by these urban curers and points out that in Kathmandu, at least (although it is probably true for the rest of Nepal as well), curing is not a primary occupation. Unlike the doctors and health assistants in government service, these curers work at their practices only part-time, spending the major portion of their days in other economic pursuits.

"Health Services and Some Cultural Factors in Eastern Nepal", presents a larger level study of conditions of health as perceived by health workers and villagers in four districts in Eastern Nepal. The article points out some of the specific changes in behavior which have come about as a result of health post outreach and developments in other fields. It goes on to discuss factors which inhibit the further growth of health care delivery, as well as those which inhibit the steps which villagers themselves might take on their own behalf. The author reviews some of the cultural implications of the fifth "Five-Year Plan" as it applies to health services in the four districts.

In some ways, one cannot avoid looking at this issue of Contributions as a kind of apologia for the use of anthropology in Nepal's development. The function and aims of the anthropologist are in many cases not clearly understood. In doing microstudies of single communities, for example, the applicability of his work toward other areas, or to Nepal as a whole is often called into question. It is for this reason that the editors have selected three works on the same ethnic group. Each study has been made in a geographically distinct area, yet one cannot avoid noticing the similarities in perspective and conceptualization of the people of each of these three areas. The third paper's presentation of the differing aspects of health concepts in a Muslim community, by contrast, shows the cultural basis of these concepts. It is the anthropologist's contention that a system of knowledge must be understood within a cultural context. Within that context (i.e. within a given ethnic group) the anthropologist's data has considerable predictive value once the geographic limits of that ethnic group are known.

To understand a system of knowledge within a cultural context has another meaning as well. A jhankri may be looked upon by health workers trained in a western perspective as a competitor, or even worse as a focus of "ignorance" and "superstition" who impedes the forces of development. The jhankri is a manipulator of the spirit world and spirits have been systematically eliminated in the context of western science. The anthropologist, because of his interest in such phenomena, may be considered to be a conservative; an anachronism who works against development because it eliminates to some extent his field of study. The jhankri, however, is not merely a curer and a manipulator of spirits, he is a manipulator of social forces as well. At times, the jhankri acts as both a psychotherapist, treating symptoms of what might be termed as anxiety in a western context, and as a social worker settling problems which otherwise break a village apart. Because the anthropologist lives and studies in a village and because he is interested in how a society (in this case a village) works, the anthropologist might find himself in a position of having to defend the jhankri against developers. Social roles in a village are complex and even though certain aspects of the role of the jhankri

might be considered to be dysfunctional in a development context, the essential role of maintaining social harmony might be missed by the outsider and the useful elements of the traditional system might be eliminated with the dysfunctional ones, without any new institutions being brought in to replace them.

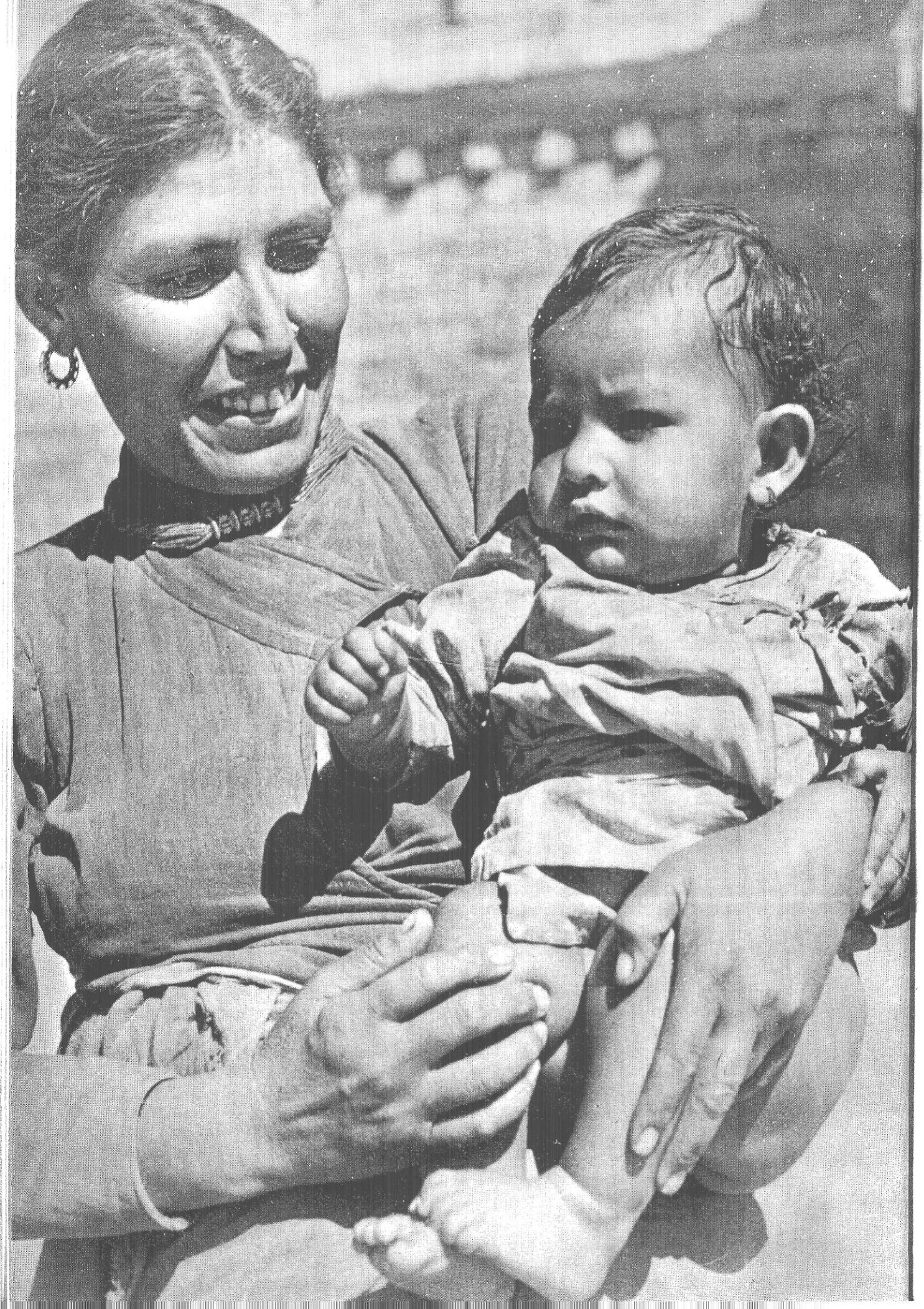
All five of these studies were done in areas where medical choices were available. A patient could select from home remedies, the services of a baidiya (ayurvedic practitioner), a jhankri or jaane manchhe, or a government or missionary hospital. These articles all point to some regularity with regards to a patient's choice as to which system to utilize. It is suggested that attention to these patterns of patient choices will be of great value in understanding problems of medical delivery at the village level.

An essential problem with regard to the use of anthropology in studies for development is that this work takes time. The first three studies presented here represent nearly six years of field research in Nepalese villages (all three scholars are now in the process of writing dissertations from the data gathered) and is systematized from what Paulo Freire calls "moments of life". These careful observations present a complex and detailed picture of conditions in a village. These are descriptive works which were not undertaken with the goal of producing explicit recommendations for development agencies. We leave it to the reader to decide as to whether or not the data suggests possible directions for development. One only hopes that the results presented in this journal will help health and family planning workers understand more about the context in which they are working and will encourage more research to be done in the area.

Editors

April, 1976





sex and motherhood among the brahmins and chhetris of east-central nepal

Lynn Bennett

INTRODUCTION

The centrality of motherhood in the lives of Hindu women is well known, but it takes on new force and reality with the intensive study of a particular group of contemporary Nepali women. In this case the women are members of the Brahman and Chetri castes believed to be representative of similar women in small villages in the Kathmandu Valley and surrounding hills. For these women child bearing is the paramount test of their identity and worth as human beings and child rearing the most enjoyable and rewarding of their many tasks.

This report attempts to give some sense of the lives of mothers and their pre-school children in a rural predominately Brahman-Chetri community on the edge of the Kathmandu Valley. Some underlying cultural contradictions are detected in the general positive Hindu attitude towards fertility and childbirth. Traditional ideas about barrenness, fertility, miscarriage and abortion and some beliefs about village sorcery as it affects these things are described. The processes of conception, pregnancy and childbirth as they are understood and experienced in the village are also recorded along with the rituals involving the mother and the early years of a child's life. Brief mention is made of Chetri-Brahman concepts of pre-school child development and the parental role in upbringing. Finally some attempt is made to outline the common childhood diseases and to give a sense of the way they are interpreted and treated in an ordinary village home.

It is hoped that the information collected in this report will be applicable in the on-going development of programs for family planning, health and educational services for the women and children it describes.

This paper is a revised version of an earlier paper entitled: "Pregnancy, Birth and Early Child Rearing: Health and Family Planning Attitudes and Practices in a Brahman-Chetri Community", which I wrote under the direction of Dr. Ferdinand Okada and which was mimeographed as Paper #9 in the Department of Local Development/ UNICEF Research-Cum-Action Project series in October 1974. The data on which that paper was based was collected from July 1972 to September 1974 as part of the field research for my doctoral dissertation for Columbia University. This revised version includes new data collected since that time. During the course of my research I have been affiliated with the Institute of Nepal and Asian Studies, and wish to take this opportunity to express my gratitude

"A Chetri mother and her child." (Photo by Lynn Bennett)

to its Dean, Dr. Prayag Raj Sharma and to its staff for their generous assistance and encouragement. I would also like to thank Alice Wygant for her help with the photography in this article.

Attitudes towards Fertility

In Hindu religious belief the need for offspring is the only legitimate reason for marriage and sex. While the new bride may have to serve her mother-in-law, please her husband and labor for the family, she also knows her most important work is to have children - preferably male children. Hindu descent is strongly patrilineal. Not only do the lineage name and family lands pass through males, but certain important rituals connected with the continuity of the family and the spiritual peace of the forefathers can only be performed by sons.¹

According to the mulki ain² promulgated in 1963 it is unlawful to marry off a girl before she has reached the age of 14. The law in itself is difficult to enforce and might have had much less effect had it not come at a time when more educated brides were becoming preferable in villages within the Kathmandu Valley.³ In the small Brahman-Chettri hamlet where my research was carried out there is no doubt that the marriage age is going up. A survey⁴ in my village revealed that of the twenty-two married women in the under-35 age group the average marriage age was 17 and only two were married before the legal age. Among the twenty-five women age 35 and over, the average marriage age was 13 with thirteen women married before the present legal age.

The reason for the traditional pattern of early marriage has been the preference (stronger among Brahmans than among Chettris) to complete the marriage ceremonies before the bride has reached menarche⁵. Of the fifty-nine women in my survey, thirty-four were married before they had begun menstruation. Of course with the rising marriage age this tradition is becoming less important and most (though by no means all) of these thirty-four women are in the 35-and-over age category. Nepali women however seem to reach menarche relatively late⁶. The average age in my survey is 15.4 which would mean that statistically at least the mulki ain and orthodox tradition of pre-pubescent marriage could both be observed if the parents moved quickly to marry a girl off after her fourteenth birthday!

As soon as a girl has begun menstruation and is married, the women of her husband's house begin watching hopefully for signs of pregnancy. One informant recalled her mother-in-law's impatience when she was eighteen years old and had not become pregnant after four years of marriage: "Whenever I had my period my mother-in-law used to say, 'How many times do you have to burst open? We haven't had any children from you. Since the day you were married you seem to have always been menstruating' She would scold me every month and then at last when I didn't get my period she was happy".

My informants all agreed that having children early was easier because the body is naram and kamilo (:soft and flexible) and can give with the strains of childbirth. A woman past 24 or 25 they said is ciplo (:over-ripe) and likely to tear during delivery and generally will recover less well. For the forty-eight women in my survey who had children the average age for the first child was 18.7. Probably due to the relative sterility which prevails during the first several years after menarche however, there was no significant correlation between later marriage for the under 35 age group and later age for the first child.

In general, Chetri and Brahman women are very positive about having children. It is a source of pride to be pregnant and a source of shame and unease to go too many years after marriage without conceiving. However, two recent brides I interviewed - both of them pregnant - did say in private that they would have rather waited two or three years longer before having children. One admitted being worried about the pain and risk of delivery. The other was in the rather unusual position of having split off from her husband's parents. Without other women in the joint family household, she has no one to help her look after the child while she works in the field and does household chores. Both women also cited the added pressure on their husband's small cash income⁷ from the child's needs for medicine, and eventually, for food, clothing and schooling. Nevertheless, both women said that they wanted children and that their main feeling was of relief and happiness that they were pregnant.

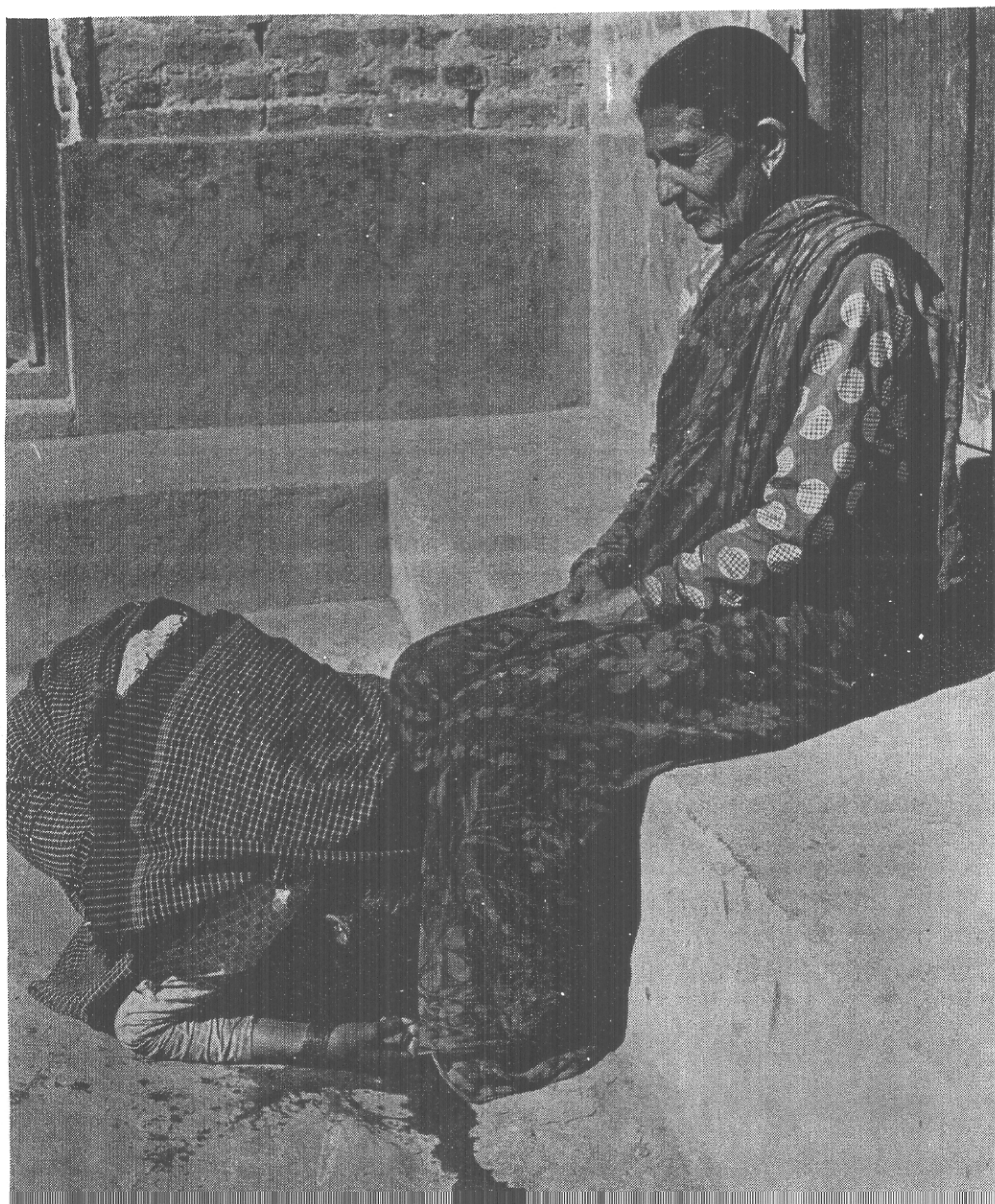
Women are relieved to be pregnant because having children - especially sons - is politically important to a woman in a large joint family. The authority structure in a Hindu family is clearly based on male superiority. Hence whatever respect, consideration or power a woman may gain must be won through skillful diplomacy and alliance. A woman's "career" in the joint family seems to go through three overlapping stages - each stage defined by the "power" she must seek to ally herself with. While her husband is subordinate to his father and mother (her sasura and sasu), she must please them. During this period any open support or affection that her husband may show her is considered disrespectful of the parents. After the sasura and sasu have died and their sons set up separate households⁸, then a woman's power comes more directly through her relationship with her husband. The third stage is when her sons become old enough to marry themselves and bring in daughters-in-law for her to command. If she outlives her husband, she may ultimately have considerable influence through her sons who have become the senior males but owe paramount respect to her.

Obviously a woman who has been unable to have children can never reach the power and security of this third stage. Furthermore, although sometimes a man is good enough to take in his wife's widowed mother, such generosity is rare and may cause other family members

to resent both the wife and her old mother⁹. A daughter is expected to serve her husband's family, not her family of birth; it is the son whose clear and accepted duty it is to honor and support his parents in their old age.

But even in the first stage of her married life, the failure to produce sons can begin to affect a woman's status in the joint family. For the mother and father-in-law are anxious to have a grandson (for the same religious and cultural reasons they wanted a son) and they are likely to be much more lenient with a daughter-in-law who has borne one.

"A daughter-in-law shows her respect for her mother-in-law by drinking that water in which the mother-in-law's feet have been washed (:gora pani khamne) and then touching her feet (dhok dinne). The most powerful position open to most women in Brahman-Chhetri society is that of sasu or mother-in-law." (Photo by Alice Wygant).



The demanding sasu will accept a slackening off of some of the daughter-in-law's traditional service¹⁰ after her first child. Also because marriage is patrilocal the new daughter-in-law is always somewhat of an outsider whose loyalty to the family cannot be entirely trusted¹¹. Once she has had a child who will be supported and loved by her husband's family she is felt to have more of a common cause with them. Slowly greater responsibility and trust can be extended to her.

The principal insecurity for a woman without sons, however, comes in her relationship with her husband. As we have said, he is a powerful potential ally. Covertly in the first stage, more overtly in the second, his favor greatly strengthens her position in the family if she can win it. Yet all the women I have interviewed state flatly that if a woman has after six or seven years, had no children, or if she has produced nothing but daughters, a man has the right - even the duty - to bring in another wife¹². One woman remembered her grandmother's narrow escape:

They say a sauta (: co-wife) had already been picked out for grandmother. Our grandmother had given birth to three daughters and she was pregnant again. (Her husband said), "You have given birth only to daughters. If the child in you turns out to be a daughter then I shall bring a sauta over you"¹³. And because she was afraid that her husband would bring another wife, she prayed to god that she would give birth to a son. She gave birth to my eldest uncle and even when she was an old woman she continued to love him more than the others. She stayed with him when grandfather died and the household split up. "This is the son who got rid of my sauta," she would say. "This is the son who has wiped away my tears. I will not stay with the others."

The elder wife finds herself with a legitimate rival for her husband's affections. The money that would have bought one good sari must now buy two of lesser quality. And in the inevitable factions in the family, there is one more person likely to side against her every time. The fact that recent laws now demand the first wife's permission (: manjuri) for a second marriage sometimes means very little in the village setting. In a case that occurred during my field work, the husband's family simply pressured the first wife until she signed the permission. She tried to put up with the situation stoically as tradition demands, but when her co-wife immediately bore a son she felt she had no more chance of happiness there. She has returned to her parents home and says she does not intend to go back.

Aside from the strong religious motivations and the deep general fear of barren women which will be discussed subsequently, it is clear that for a woman, personal fulfillment within the family - indeed, her very social identity - depends heavily on being a mother. Yet despite this positive attitude about birth and fertility, there is still a strong ambivalence in the Hindu world

view about their ultimate value. The ambivalence is part of a deeper religious and philosophical question: does man achieve spiritual salvation through participation and contribution to the ongoing organic processes of life, or through control and withdrawal from them? Hinduism presents both options as legitimate.¹⁴ One can follow the ancient Vedic tradition, and be a householder, daily honoring the gods, year after year sustaining the ancestors who went before with ritual feasts, and above all, producing offspring who will in turn provide ritual sustenance after one's own death¹⁵. This is the "worldly" path followed by most Hindu villagers. But the villager is always aware that there is another - perhaps more ultimate - path, tangential and yet interwoven with his householder's life. He knows that some men have chosen to become sadhus, giving up caste rank, family and wealth and seeking by control of the bodily senses and emotions to attain release from the very world of organic change and decay in which the villager finds himself immersed. He may say openly that most of the holy men who come begging at his door, naked and smeared with ashes from the burning ghat are charlatans and rascals. But he would not deny that some were genuine and that there were - in this or that temple or holy spot - very powerful saints who had freed themselves from the desires and fears of the flesh.

In other ways too, ascetic values penetrate the villager's "worldly" life. The classical asrama theory is present as an ideal symbolically expressed in the bartaman life cycle ceremony when a high caste boy is given his sacred thread.¹⁶ Moreover fasting and even sexual abstinence are periodically required of the villager in the course of his religious observations. When questioned as to why they fast, my informants never professed any lofty ascetic or spiritual goals. They spoke instead of simple bodily purity which they had to attain to be fit for this or that required worship. However, if we look into these beliefs about purity and pollution which so dominate village religion, we find that on another level of analysis, they do imply the values of ascetic control and withdrawal. For it is those very organic processes - eating, elimination copulation, birth and death - which the ascetic seeks to control and ultimately avoid - that the householder perceives as polluting. Thus, even though the sadhu and the villager have chosen different paths, they share a common value system. Nowhere is this common ambivalence towards sex and birth more clearly expressed than in the villager's understanding of these processes in terms of purity and pollution. Let us turn then to the villagers "symbolic physiology" of conception and birth.

Conception

Explanations as to how conception (:garbha basne) takes place vary from the poetic and religious to the more practical. Often women give several types of explanations in succession. One

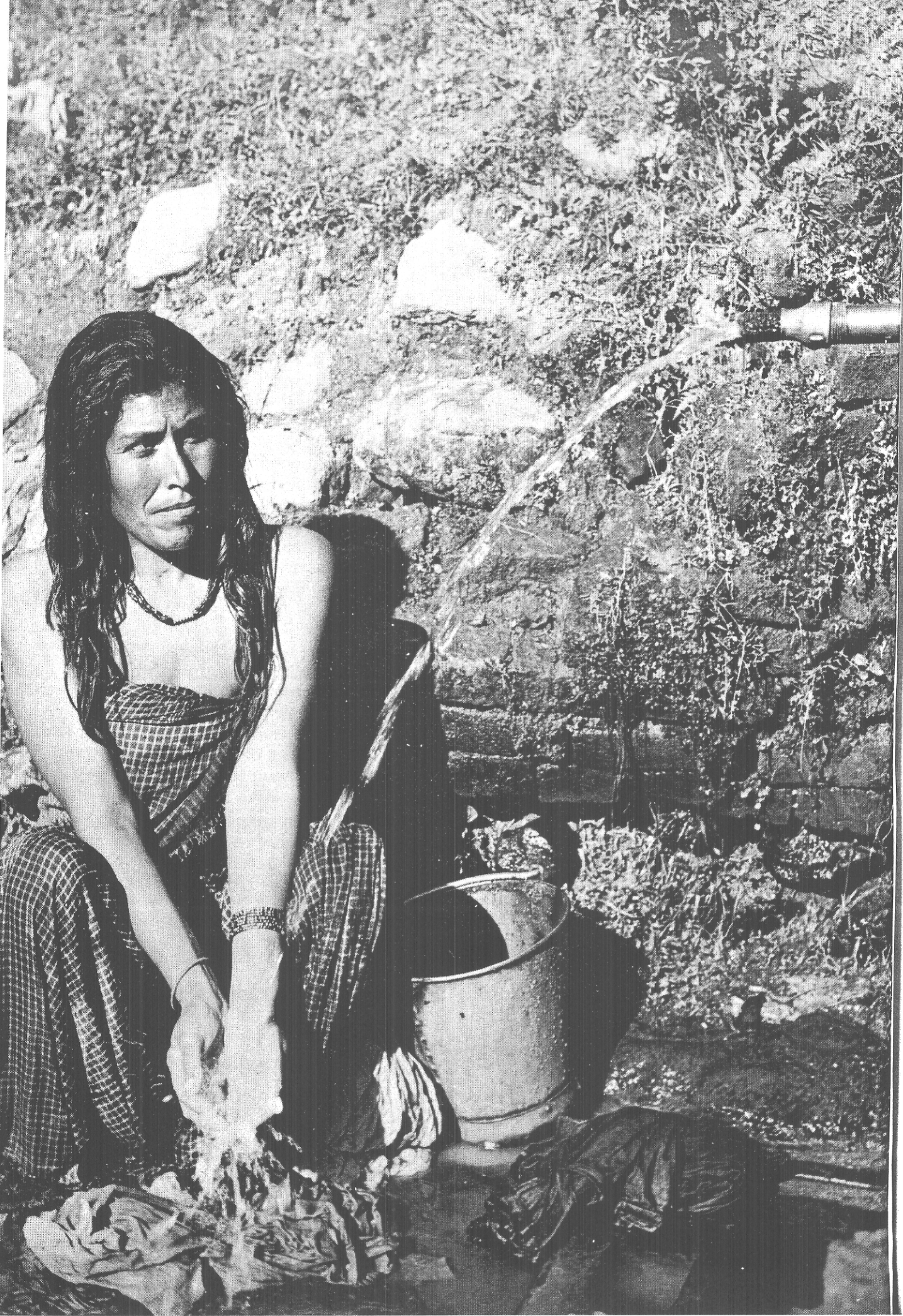
fairly typical description began: "The seed (:bij) is the man's and the woman's blood goes into the seed and forms the baby. A child is found if god gives the seed and that is a matter of karma." A male informant explained that both men and women have seed which is liquid -- though he had never seen female seed. During intercourse the seed mixes in the woman's vagina to form the child whose sex is determined by "whichever partner's seed was stronger."

Though none of my informants expressed the concept of an egg deposited monthly within the woman's womb, there was a strong idea that the woman has a fertile period connected with her menstrual cycle. As one woman explained:

If a man doesn't sleep with his wife on the fourth day (after the beginning of the menstrual period) he gets the pāp (: sin) of a murderer, because at that time there is a child in the womb -- a little blood is still coming. If the wife is at home and her husband is away she has to face toward Sūrya Nārāyan (: sun deity) and offer dhok (: gesture of respect with folded hands) and ask for forgiveness saying that she is helpless as her husband is not there. They say that on the fourth day the rītū dān (rītū: season or period of fertility; dān: religious gift) has to be made.

Some women, though they all knew about rītū dān on the fourth day, said they did not always follow it because often they were still bleeding and they felt either ashamed or disgusted at the idea of intercourse while there was still blood, so they prayed for forgiveness. Even if the orthodox rītū dān is not performed by every couple on the fourth day of every month, it is still a common subject of sexual jokes and teasing. For example, recently a group of women who were planting rice seedlings, teasingly asked an older Chettri man when it was going to rain as the seedlings would soon dry up without more water in the paddy field. He, nodding towards his youngest wife who was in her fourth day, said with a grin that it would rain that night for sure. There was laughter from the women and the young wife flushed and kept on planting rice.

A woman's fertile period includes not only the fourth day which is the husband's religious duty, but also the fifth and the seventh through the fourteenth day after menstruation¹⁷. On the sixth day and after the fifteenth day after menstruation a woman cannot conceive and sleeping with one's husband at that time is only for pleasure. The first three days of menstruation are also infertile and sex during this period is very sinful, though most women thought there were probably some shameless couples who indulged even then.



A woman's fertility, even at these specified times however, is not conceived of as simply the automatic working of human physiology. For, all my informants agree that the number of children a woman will have and even their sex is determined by her own moral history - her karma. Thus, although women know that coitus during the aforementioned fertile periods is necessary for conception, they do not see it as sufficient in itself. A woman's fertility ultimately rests on the spiritual merit that she has accrued in preceeding lives. A large brood of healthy children - providing they are not all girls - is not only proof of, but reward for her past virtue¹⁸. Even the supreme being, Bhagwan, can only give his gifts according to the laws of karma.

To return again to the description of conception given above, perhaps its most significant feature in terms of symbolic physiology is the connection between menstrual blood and the formation of a child. The connection was present for all my informants. Invariably when women were asked about conception and pregnancy their answer would contain the phrase: "Das mahina ko ragat jamera nani pauncha." (After ten months of blood have collected (solidified, thickened) a child is born.) In fact it is a common form of abuse for an irrate mother to call her naughty child "mero rakat ko dallo" (: a ball of my blood). So although there are many versions of how the child is started - i.e. a "seed" given by the father, by both parents, by god or by the laws of karma - everyone is sure that it is from the blood that would have been lost in menstruation that the child grows. To fully understand the symbolic importance of this fact however, it is perhaps necessary to know the meanings which Nepali Hindu culture attaches to menstruation and menstrual blood.

Menstruation

For Nepali Hindus, as for the peoples of many other cultures, menstruation (para sarne) is not only connected with fertility and female sexuality, but it is highly taboo. The more appropriate word in the context of Hindu culture is "polluting" or bitalo. Menstruating women and menstrual blood are two of a host of things (such as left-over food, feces, members of certain lower castes, etc.) contact with which causes a high caste Hindu to fall into a state of ritual impurity. In this state of defilement (called jutho, bitalo or sutak depending on its cause) a Hindu may not eat, approach a well, approach the gods or touch those who are not similarly defiled until he has purified himself.

For three days out of every month then, all Brahman and Chetri women between menarche and menopause become polluted and untouchable.

"A woman bathing on the morning of the 4th day after menstruation. She must wash her body, hair, clothes and bedding before she is choko (:pure) enough to touch an initiated adult male." (Photo by Alice Wygant).

As they themselves explain, "We become like daminis. (:female members of the untouchable tailor-musician caste). We become like dogs." For these three days a woman must not enter the kitchen or touch food or water which others will eat. She may not comb or oil her hair and she sleeps separately in a downstairs room. Above all she may not touch initiated karma caleko high caste males. Some especially strict women avoid touching even children (except those whom they are nursing) and other women. In fact the idiomatic term of menstruation is na chune which means "not touching". Older informants tell me that in the time of their mother-in-laws (i.e. the "old days") menstruating women were hidden from the sun and the sight of all males in a dark room for this period. Food, water and a brass kopara for bodily elimination were brought to them and they could not stir out or even speak to others until the early dawn of the fourth day when they had to bathe and purify themselves before the sun rose. During those three days, each step they took beyond the room brought them the pāp equivalent to having killed a cow. Nowadays such strict seclusion of menstruating women occurs only during a young girl's first three periods, the first and most important being a twelve to twenty-one day seclusion called gupha basne or "sitting in the cave"¹⁹. Nevertheless it is clear that the ritual impurity of menstruation and menstrual blood remains strong. Women themselves while acknowledging it as the source of their much wanted children, connect menstruation with sin. As one informant explained.

"They say that this (menstruation) is a curse given by Bhagwan (:god) to women.... Bhagwan has distributed pāp (:sin) between the Ganga (:Holy river goddess), women and the daurah (:wood, firewood). Just as when wood is set on fire, some phijh (:foam) comes - that foam is sin. They say that when there is foam in the Gangaju then the Gangaju has become na chune. They say that our na chune is also sin and if our sin is not secluded then they say that it becomes a great sin.... Women must have sinned. I don't know. It may be that the sin which has been committed long ago has been distributed to all."

The most important occasion during the year for Brahman and Chetri women is the combined festival of Tij and Rishi Panchami²⁰ which center on purification from sins connected with menstruation. Both the women's own explanations and the symbolism of the bathing rituals on Panchami leave no doubt about the festival's meaning. The most explicit act occurs in the privacy of pre-dawn darkness when every woman must rub rato mato (:red mud) on her genitals three hundred and sixty times and then wash herself clean with water three hundred and sixty times²¹. Other bathing, washing of hair, brushing of teeth (all done three hundred and sixty times each) occurs later in groups by the river. All of this, women say, is to purify them from the possible sin of having touched a man while menstruating.

It seems surprising then, with these strong negative feelings about menstrual blood that there should be this almost equally strong rule enforcing coitus on the fourth day when, as my informant said, "a little blood is still flowing". In a sense, however this apparent paradox is but an expression of the pervasive Hindu ambiguity about sex and fertility mentioned earlier. Menstrual blood representing sexuality is dangerous but (for the householder at least) necessary and potentially good if it can be controlled, for it is the substance from which a child is formed. A woman's menstrual period is when she is most blatantly sexual and thus strict sexual abstinence for the first three days represents control imposed on this potentially unruly and destructive force. Yalman in his analysis of Ceylonese female puberty rites speaks of ritual acts capable of converting the impure and dangerous fertility of a young girl at menarche into a pure fertility which is acceptable and useful to the community²². This same transformation is effected by the aforementioned gupha basne

"A group of women take their ritual baths on Rishi Panchami to purify themselves from the possible sin of having touched a man during their menstruation period." (Photo by Lynn Bennett).



rite which Nepali women undergo at the onset of puberty. And thereafter every month the ritual bathing and washing of hair & clothes on the fourth day repeats this process of purification wherein the force of sexuality is cleansed and channelled²³. As one woman put it: "The blood is the same. But the blood which is impure or spoilt comes out when we are na chune. When the na ramro (:bad) blood has come out then the baby is formed out of the ramro (:good) blood."

Perceived Effects of Menstruation and Intercourse on Female Health.

Carstairs²⁴ has written that one of the prevailing concerns of his male Rajput informants was that they would become physically (and spiritually) weakened if they overindulged their sexual appetites. Following the same reasoning that motivates the celebrate Hindu holy man, Carstairs' Rajastani peasant man believed that loss of semen is accompanied by proportional loss of strength. Not surprisingly, the same view - though accompanied by much less anxiety - is held by Nepali Hindu males. It has not, however, been previously recognised that Hindu women hold a parallel view about their own loss of strength due to the combined effects of menstruation and intercourse. Nepali women accurately observe that a woman who has a heavy flow is likely to have sunken eyes, be generally weaker and perhaps even lose weight. Except for the fact that they have no direct control or responsibility for its loss²⁵, they feel about menstrual blood much the way Hindu men feel about their semen. In fact women repeatedly explained that the reason males are stronger than females is that males do not lose their strength through menstruation every month. Just as Carstairs reported frequent requests from his male informants for medicine to restore strength lost through intercourse, so I have constant requests from women for medicine that will replace what they lose through menstruation. All sorts of "tonics" for this purpose are prepared by gubajyus, vidyas and others and sold at steep prices.²⁶

Nepali women do not complain greatly of cramps or pain during menstruation. Slight backache or pain in the abdomen often forewarns them that they are about to become impure and may persist for a day or two. Occasionally cramps may be severe and various homemade medicines may be given. One such recipe was reported to me by an older Brahman woman who prepared it for her young daughter-in-law²⁷. The medicine is pleasantly sweet and the sixteen year-old bride reported that it worked well for her.

Occasionally women complain of discharging "black blood" during their periods. This is a sign that a witch (:bokshi) has caste a spell on them and help must be sought from a gubhajyu or jhankri to reverse the curse.

Vaginal discharge, if it is at all noticable, is felt to be even more debilitating than menstruation. Women are greatly ashamed of this parar of seto pani (lit: white water), which they say occurs when the body is internally "heated" either by a fever, over indulgence in heat giving foods (like honey, ghee, meat etc) or too much sex. It is one of their most frequent health complaints and it is associated with weakness, dizziness and loss of weight or "drying up".

Women's ideas about the ill-effects of intercourse are less clearly related to physiology and generally more vague than their anxiety about menstruation and vaginal discharge. Often women informants said that they didn't enjoy sex either, because it made them weak and thin or because they already were weak and thin due to illness, poor diet repeated child-bearing or simply hard work. But they could never explain why or how intercourse had this debilitating effect. Certain patterns in my data however, suggest that women's attitudes towards intercourse correlate with the basically puritan nature of contemporary Hinduism. Usually negative responses came from women past their first youth and already the mother of several children. They would often admit having enjoyed sex when they were a taruni. Taruni has somewhat the same meaning as "teenager" in American culture with the same connotations: physical development, narcissism, frivolousness, energy and an awakening interest in the erotic. Consistent with this is the belief that in the first few months and years after marriage, intercourse makes a woman fat and healthy-looking. Young brides are often teased when they return to their parent's home to visit about how fat they've become and about the probable reason. But this taruni period of enjoyment should end after a woman has borne one or two children, and sex after this begins to be seen as debilitating, also women say they are less attractive to their husbands since childbirth has stretched their vaginas. Women beyond twenty-five or so tend to be extremely reticent about seriously admitting pleasure in sex - even though they may enjoy talking about it and miss no opportunity for a suggestive joke. One informant did go so far as to say that she might enjoy sex "if my husband gave me nutritious food and were healthy and strong again". As far as I can see she is healthy and strong and very attractive too, but she is in her early thirties and even more significant, she is the mother of a young teenage son. A generation ago she would have soon become a mother-in-law. It would have been shameful for her to become pregnant with her own daughter-in-law in the house. Now, of course, women do not assume this prestigious rank until later, but the feeling that it is immature and even wanton to admit enjoyment when one is no longer a taruni remains strong. Once a woman's sexuality has fulfilled its function and she is a mother then its legitimacy decreases. Thus, although the belief of "older" women that intercourse is in a vague way physically harmful to them²⁸ may partially be a reflection of the fact that often their early married life of child bearing and hard work has indeed "worn them out", it may also serve to re-inforce the strong

cultural ideology that sex when not necessary to produce the next generation, is spiritually harmful.

Although most women either did not feel -- or refused to admit -- pleasure in sex, they were frank in admitting the political necessity of maintaining their husbands' affections through sex. As one woman put it: "(My husband) needs a lot. After all, he is a man -- all that matters for men is that they should be able to 'sleep'! If you allow them to 'sleep' with you then they love you. Otherwise they don't".²⁹

Hence instead of gratefully sharing the "burden" of sex with a co-wife, women were usually upset and angry when their husbands went to co-wives³⁰. While informants maintained their own self-

"A new bride (left), still a taruni (:young pubescent woman), and her sister-in-law (right) who has had several children and now calls herself a buri (: old woman) in jesting self-mockery. Note the handkerchief placed over the first vermillion mark which the groom has just placed on the part of the bride's hair. If a witch (:bokshi) saw the mark she could curse the bride to be barren."
(Photo by Lynn Bennett).



images as "respectable" women who passively accepted sex as the wife's duty, there was frequent projection of a sexual voraciousness on to the informant's co-wife to explain the husband's perceived favoritism. One woman went so far to accuse her co-wife of wanting intercourse seven times in one night, and of physically restraining her husband from withdrawing after climax.

It is significant that co-wives (followed by ego's *hu bro wi* (: jethani and devrani)) were the most frequent suspects in witchcraft involving alienation of the husband's affections, sterility, miscarriages, general weakness, and loss of weight. In fact, in several cases women later confided that their earlier complaints about being too weak, thin, and "dried up" to enjoy sex were actually the effects of witchcraft by a female rival in the household.

Clearly women's attitudes about sex and their own fertility are complex, and even ambivalent. They are inevitably bound up with the structure of the joint family within which women must struggle for security and identity -- a subject which is beyond the scope of this paper.³¹ Nevertheless, I would like to relate here one further observation, which seemed to have bearing on women's attitudes towards family planning and contraception. The theme recurred constantly in my discussions with women about the effects of intercourse and childbearing on women's health. The idea was mentioned earlier that all matters concerned with reproduction take a toll on the woman's vitality. If a woman is loved and well looked after, however, her husband, and to a lesser extent, his family and her own family of birth; will replace the strength she loses in childbirth and intercourse. Thus the new mother is given rich foods publicly by the family and the amorous husband and wife feed each other special foods on the sly as a sign of affection or as a romantic prelude to sex. In both cases, women believe that if they get enough nutritious food neither sex nor childbirth harms them.

Still, it came as a surprise to me when I interviewed village women about family planning and found the same concept operating there. One woman was the village mid-wife -- a traditional woman who did not believe in birth control. The other younger woman did believe in it in principle, though she could not openly say so in front of the older woman. But both viewed contraception like everything else connected with reproduction, as debilitating. Both believed that various birth control methods were good for women only if they could get nutritious food along with them.

Here is part of one conversation:

LB: Do you think family planning is beneficial to the women?

- Young Woman: They put in the loop -- when that is put in then the body dries up.
- Midwife: They say that when you put the loop in then there is risk that it will reach the heart and you will die.
- Young Woman: She (pointing to me) has also put it in... But she is healthy. She eats fish, meat, and fruits. Her food is khurakilo (: nutritious). As she hasn't had any children yet, her health is good. But others do not have nutritious food. And they have placed the loop inside them after they have already given birth to children. Once a woman gives birth she becomes weak. You (pointing to me again and laughing) do not have to eat dhiro (: wheat or corn flour mush) like us! What strength do you have when you only eat chillies and salt? Even you would dry up if you put in the loop under such conditions. A person who puts in the loop has to have food which gives strength.
- Midwife: One who has put in the loop does not even have blood in the nails. They become very thin and when you look at them they are so yellow.
- LB: But if you take pills, this medicine which prevents conception, then is that all right?
- Young Woman: That also makes you weak and thin.
- LB: But when I took it, I grew fat.
- Young Woman: If you take nutritious food, then the medicine also benefits you. And if you don't eat (nutritious food) then you grow thin.
- LB: Yes, but if you have many children then the mother also becomes weak and thin.
- Young Woman: When you have many children then you become weak and on top of that if you take (contraception) medicine, then you grow still weaker.
- Midwife: As long as the food is nutritious, the more children you have, the better it is for the body.
- Young Woman: She means it is good to have babies.
- Midwife: All the phohar-maila (: dirt and impurities) in the body is cleaned out. You get nutritious food to eat as a sutkeri (: woman who has recently given birth). The blood keeps changing.

Young Woman: Maiju gives birth to one baby each year. As long as the baby is in the womb, then your baby looks big and fat. And when you give birth to a baby and gets to eat the food of a sutkeri, then you grow very healthy. And then when you get pregnant again you still remain very healthy. Maiju has given birth to twelve children now and she is as strong as an ox.

Barrenness, Miscarriage and Abortion

There are five categories of inauspicious women in Bahun - Chettri society³² all of them suffer in some way from impaired fertility. They are: 1) Biduwa: the widow whose legitimate fertility ended with the death of her husband - though the colloquial name for widows, i.e. randi (: prostitute), indicates that she is still suspected of illegitimate fertility. 2) Aputri (from Sanskrit: "without son") - a woman who has never conceived. 3) Kagab dhwa or ek bita kouwa (named after a kind of crow (:kaga) which has only one offspring and is considered untouchable) - a woman who has borne only one child and is thereafter infertile. 4) Mrit balak (: dead child) - a woman who has only still births. 5) Srabad garbha - a woman who always miscarries.

Less sanskritic terms for a childless woman are banjo, taro and tari but all these are likely to be uttered directly only in anger or abuse. As we mentioned earlier, such a condition if it persists, is considered karma ko kura - a matter of the woman's own moral history in previous lives. Specifically the sin of inducing an abortion (on one's self or on another), abandoning or causing the death of an infant or a pregnant cow (: garbini gai) in one life inevitably leads to the childless condition in some future life. Such women eventually become the object not only of pity, but also of suspicion and mild ostracism. They are considered inauspicious (: alakshin) and although they are allowed to do puja and participate in other religious activities, they gain no merit because the gods will not accept what they offer. With the exception of older widows, they are excluded from attending at childbirth for fear they will endanger the mother or her child. They are also likely suspects in any witchcraft that is performed. The other negative factors - the fact of their low status in the joint family and the likely addition of a co-wife - have already been discussed.

Fortunately, however, a woman is not clearly labeled aputri until many years have passed and many remedies and prayers have proved ineffective. For witches (: bokshi) are known to exist in every village and a bokshi can make an innocent woman unable to conceive "by closing up the entry to her womb so the seed can't get in." In the hamlet of twenty-one Brahman-Chettri households where I worked, one woman named (in a whisper) four women and surprisingly one man (who was at the same time a jhankri) who were known bokshis, and she felt that there could be others. Not one

of my informants doubted the power of bokshis and all could give examples of witchcraft that had been worked on them and their families. Quite a few said that they had at one time or another been temporarily rendered infertile or caused to miscarry by angry or jealous women who knew the powerful mantras of witchcraft.³³ One becomes particularly vulnerable if a bokshi catches sight of one's menstrual blood, or touches or sees the food one is eating. Brides are also extremely vulnerable if a bokshi sees the red sindur powder which the groom has placed in the parting of her hair on the wedding day (see photo 5). Hence this red line is usually covered with a handkerchief on the day of the wedding. Powerful bokshis can also creep into the house at night in the form of a cat to suck their victims blood. Many women have showed me the bluish bruise-like mark which bokshis leave when they come as cats. Yet another method of casting a spell is putla garne which will be described below.

Fortunately however, there is usually a gubhajyu, jhankri or simply a janne manche³⁴ (:knowing person) somewhere that can break the spell. Much has been written about these practitioners and it is beyond the scope of this report to catalogue their numerous remedies in detail. Instead I will try to give a sense of how these practitioners work by recording one informant's description of a sure she underwent for infertility at the hands of a "lama":

He was black and frightening.... He felt my pulse.... and then he placed his chasma (:spectacles) on the forehead and looked.... He said "Did that person cook syel (:doughnut-like fried bread) and give it to you? And did you eat it in a relishing manner?" And I said yes.... And he said that some evil (:bigarh) had been done at my dhatu-stan. Dhatu stan means the thing from which you urinate. He said that maybe there was something flowing from the dhatu-stan. (This would be the parar or vaginal discharge). He seemed to know all about my illness... so I admitted it was true. He said I felt dizzy, that my waist hurt and that when I became na chune then it hurt we as if I were having labor pains (:nani paune betha). And I said it was true. Then he said he would come on Tuesday which is a very powerful (:karah) day of the week. He brought his son and another janne manche from his village because he was afraid that while he was doing his work another bokshi might kill him. He sent my husband to get oil and chicken eggs that he needed and then at ten o' clock in the night my treatment began....

He did all sorts of things. He had a khukuri and with it he made as if to cut up my body. He cut at my stomach like this, and at my spine-base (:daralo) and he bit me. The Lama asked me where my pains were and wherever I told him the pain was he bit and sucked there. He put his mouth there... on the body. He told me to move aside the cloth and there he would suck. "Look, there's the hair coming out!" He would say. He would say that the hair which had been buried as putla (:the hair or piece of cloth belonging to the victim used to cast spells) was coming out. They say that the bokshi takes our putla hair or piece of cloth and buries it. And if they have buried it in a simh (:marsh, bog) then we become bloated (:sun-ninu); and if they have buried it in dry earth (:mato) then we dry up. And so he said that this was what had been done and he took it (the putla) out. Meanwhile he is sucking away at my blood and he is biting. The Lama keeps telling me to be still and I am scared. I keep wishing that I hadn't gone through with this.... Everyone was sitting and watching (family members and the Lama's assistant). He kept boiling water and pouring it on my daralo. And he had lit a ranko (:fire brand) and it is spurting flame. Then he told me to hold down a chicken egg with my feet.... My husband was scared stiff that he would cut away my toes also. He blew on the khukuri...and then he slashed down and only the egg was cut: Nothing happened to me. There was something black in the egg. "Look - that is what is wrong with you (:betha):", he said. All that was over at one o' clock in the night. My husband gave that Lama forty rupees and six pathis of paddy for payment. After this I became na-chune once and then I conceived my little daughter. Otherwise I hadn't had any children for seven years since my son's birth.

This account perhaps gives some idea of the kinds of treatment available from jhankris, gubajyus and other specialists for women seeking children. Often, too, women visit the temples of powerful gods and goddesses and vow to give them sacrifices in return for a son. But all these efforts will prove futile if it is the woman's karma to be childless and not just the work of a bokshi or a temporarily displeased god.

Miscarriage (:adhekro, a premature baby, miscarriage or deformed child)³⁵ seems fairly common. Seven (approximately 14%) of the married women in my survey had at least one miscarriage - some had as many as five. Miscarriages are generally thought to

be caused by witchcraft, although one informant said they may also occur if the husband had mojh (:venereal disease) when he slept with his wife.

Abortion or induced miscarriages (: nani pyanknu; nani palnu) are naturally more difficult to get figures on. But they do occur. One village woman who was a regular childbirth attendant knew the grisly recipe for baccha marne ausadi (:medicine to kill the foetus) in which mercury (: paro) scraped from the back of a mirror seemed to be the chief ingredient. Village gossip also attributed one death during my period of research to taking such medicine. The victim was an older and very poor Brahman mother of five who was ashamed to be pregnant because her sons were grown and there were daughters-in-law in the house. Women say they are uneasy about taking any medicines (except tonics or vitamins) and especially injections during pregnancy for fear that it will cause them to abort. Village women also make a strong moral distinction between early and late abortion. As one informant explained: "If you take the medicine (for abortion) during the first one or two months then it's just a lump of blood and there's no harm to you. But if you take the medicine after the baby has life in it (ie. in the 5th or 6th month) then it becomes a great sin."

Pregnancy

There are many synonyms for pregnancy in the Nepali language: dui-jiu ko hunne (:being with two bodies), na sakne jiu ko (:with an "unable" body), bhuri ma bokne (:carrying in the belly) and nani bokne (:carrying a baby). Because of the Nepali system of counting from the month as it begins instead of the completed month, pregnancy is said to last ten months. As soon as a woman is even a few days late for her period - and because of the pollution rules a woman's cycle is necessarily public knowledge - the other women of the house begin to tease and question her. Generally the rest of the village will not find out until the third or fourth month. If not for gossip, outsiders would not know that soon because the loose dhoti and bulky patuka (:waistcloth) which women wear makes physical signs of pregnancy difficult to detect. Many women feel ashamed or embarrassed about their first pregnancy, especially in front of their father-in-law or their husband's older brother (with both of these relatives a woman has a strict respect-avoidance relationship). As one informant said, "We feel ashamed because what we did in the dark with our husbands now puffs out for all to see." But behind the necessary shyness and modesty there is always a strong element of pride.

Women say that after conception they get thinner for a few months before their breasts, vagina and stomach begin to enlarge. This initial loss of weight is due to asani (:nausea) and lack of interest in food which seems similar to the western concept of "morning sickness". Every woman is said to have one particular food which makes her ill during pregnancy. Interestingly it is

usually the cheaper, less popular foods like dhiro (:corn or wheat flour mush) or gundruk (:dried edible leaves) that tend to be avoided by pregnant women. To the limit of their financial ability the family, neighboring friends and members of a pregnant woman's natal family will try to feed her rich, nourishing foods during and after pregnancy. Ghee, meat, liver, milk, fish, eggs, curds and a syrup-filled sweet called jeri are favored - though there are many variations and some will not give meat or eggs for religious reasons. Amilo (:sour, tart) foods such as pickles and achars, and piro (:hot, spicy) foods should not be given even though the pregnant woman may crave them. An informant explained, "They say that the foetus which is made of blood is burned by that which is amilo or piro and becomes restless with pain."

Perhaps because they have seen so many miscarriages at various stages of development. Nepali women seem to have a fairly clear picture of how the foetus is formed. As one old woman described the initial process, "First a seed like that of til (:sesame) falls and then it grows as big as the dhan (:rice). Then it becomes as big as the makai (:corn) and then as the lapsi seed (:Spondias acuminata) and blood congeals and it grows as big as this (showing her fist) by the third month." Sometime between the fifth and sixth month it is thought that the sas or life breath enters the child's body. From that point on, the mother will feel the infant kick and it is considered a human being. Should a miscarriage occur after this stage, a modified religious rite which will be described below (p. 34) is required for the foetus's funeral. If a woman dies while she is pregnant, the foetus is removed from her body and replaced with a mana of uncooked rice. The unborn child and its mother are then buried on opposite sides of a river. It is considered extremely inauspicious for a woman to die while she is pregnant (or while she is menstruating) and both her spirit and the unborn child's are likely to haunt the village.

All informants agree that female children develop faster, are stronger and more difficult to deliver than male children. Sas enters the female at five months and the male only after six months.

Intercourse is suspended after the sixth month because women say it becomes uncomfortable for them. Usually a pregnant woman is allowed to go and spend some time in her maiti (:natal home) where her work is always light and her food the best. But after the seventh month it is felt that a woman should remain in her ghar (:husband's home), for it is not proper for a daughter to give birth in her father's house. If, because of a quarrel with her husband or some member of his family, a woman does give birth in her maiti, she does so outside the main house in a goth (:cowshed). Only her mother and female relatives may attend her or even see her during delivery and for the ten days of birth pollution which follow³⁶.

The whole development and delivery of a child is conceived of as a process of heating the woman's body. Thus if the body becomes greatly over-heated before full term, the child may be lost. For example, one woman explained to me how she miscarried after unwittingly eating a whole mana of honey in her sixth month because she hadn't known it was a heat-producing food. After the eighth month of pregnancy the woman's entire body is heated. "The whole body becomes weary. You don't feel like eating anything and there is a fever within you. From the eighth month there is atma joro (: fever which is not apparent physically, nevertheless still present within) and you are unable to do heavy work." Village women know that labor is always accompanied by a fever, and experienced women can judge the amount of time left before a woman will deliver by feeling how hot her forehead is.

Often during the last two months, though the stomach and breasts get bigger, a woman's face is said to get thinner and her eyes become sunken because the unborn child's appetite is growing and it is eating more and more of its mother's food. At this time special effort will be made to feed her well. She usually continues to do much the same work in the fields and around the house with the exception of carrying heavy loads. Almost all informants describe the onset of labor as interrupting some task - laundry, cooking, etc. - which they stoically finished before informing anyone of their condition. However there are certain ritual prohibitions on the activities of pregnant women. After the fifth month they will not be allowed to do puja or go to a temple. And after the eighth month a woman may not cook dāl bhāt (:lentils and rice) for her elders or touch water which they are to drink.

Labor and Delivery

Sometime before labor (: betha lagnu, betha chalnu) actually begins (a few days or even a few hours) the child drops lower in the womb to the head of the birth canal (dhunginu: from dhunga (:stone), to drop like a stone). At that point the child has turned (pharkayo) to its birth position. When labor begins and a surehni (:midwife) or other experienced woman is called, she will feel the mother's stomach to determine where the child's head is. A normal head first presentation is called a taro baccha. (:upright baby). Feet first presentation is called ulta janmeh ko baccha (:reverse or upside down birth). If such a child is a male he must later be sure to step over his wife at the beginning of each labor, so that his children are not also born feet first. Such deliveries are thought to be more dangerous for both the mother and the child. The most difficult however, is a terso baccha or transverse lay, and for such a delivery villagers say they can do nothing except try to get the mother to a hospital and a doctor.

It is considered extremely important that the mother be kept warm during and after the delivery. Even in the warm summer months, delivery usually takes place near a fire - either an open hearth on

the mud floor of a portable clay bowl full of coals (:makal). Ghee or oil will be heated and rubbed (:seknu) on the mother's back, rectal area and stomach. This massaging is always a downward motion on the stomach and on the back moves from the spine outwards. It is thought not only to ease the pains but to speed the passage of the child. The woman in labor will be dressed in a petticoat and thick cotton dhoti for warmth. Her blouse may be removed occasionally for the massages, but the waist cloth is never removed. It is tied high above the stomach "to prevent the child from going up to the mother's mouth." If she is hungry a woman will be fed foods such as hot milk, ghee and rice, or a kind of heated sugar water (:misri pani) which are considered to be internally warming foods. The laboring woman is expected to run some fever and to perspire, because the whole exertion of labor is conceived of as an internal heating of the body which must be aided by the external fire, warm oil rubs etc.

In the village where my research was conducted there are no longer any surehnis or midwives. Instead, there are two experienced women (janne manche), one or both of whom are usually called. But these women seem to be of very different types. One is an older Brahman woman from a respected family who is called for advice in determining the child's position and the probable time of delivery.³⁷ She may also help with massaging, but she does not involve herself with the polluting task of cleaning up the after birth or washing the mother's blood-stained dhoti. She is not paid, but merely given some of the special foods brought for the mother after birth and fed on the eleventh day naming ceremony. The other woman is from a poorer Chetri family and does perform the tasks of cleaning up which were traditionally performed by the lower caste (but not untouchable) surehni. This woman expects a cholo (blouse) in return for her services as well as food. Neither woman however are qualified to "reach inside" if necessary to aid delivery the way traditional surehnis are said to have done.

Another category of specialists also absent from the village studied is the dhai ama. She is less involved with the technicalities of birth than the surehni though she may aid in the massaging during labor. Her main tasks are washing and oiling the newborn infant and attending to the mother during the sutak confinement by rubbing oil and perhaps washing soiled diapers and clothes. Many women remember female slaves or ghartinis (of clean and often high caste status) who filled the role of dhai ama for all the women in a large joint family. Even though many were slaves, the status of a dhai ama seems to have been higher than that of a surehni. Moreover, surehnis are felt to engage in slightly dubious occult practices. Women say that once one has called a surehni in (as many would like to do for only the first birth), she has the power to make subsequent deliveries long and difficult if she is not called again. Also many surehnis are said to save the supari (betel nut) on which the umbilical cord of the new-born child

has been cut. They then sell this nut at a high price to a barren woman who places it inside a banana and eats it on the fourth day after her period in the hope of becoming pregnant. A further practice of surehni which one informant remembered from her childhood and found alarming was that of smearing the now-born infant's mouth with some of the blood of childbirth. The surehni had said this would make the child's lips red when it grow up.

Men, children and all women who have not yet given birth to their own children are excluded from the delivery area. The presence of the latter group is said to make the woman's labor longer and more painful. In fact women say that the fewer people who know about it the shorter the labor. Children, however, seem to ignore the ban quite often, because many women remember vividly the birth of their brothers and sisters. Men are not even supposed to hear a woman's cries during labor and the shame of letting them hear seems to be a strong incentive to stoicism on the women's part. However, some women reported that their husbands had helped them with the early stages of labor when they were still reluctant to let anyone else know. Women are discouraged from calling on the name of their mother during labor because it is said that three mothers will then bear the burden of the labor pain-the delivering woman, her mother and mother earth.

The breaking of the waters is called sano sutak and after it labor which becomes more intense is called kannē betha. The women say that the seto pani (:white water) which comes is helpful because a rasilo (:wet) birth is easier than a dry one. During labor and delivery women do not lie prone. They either squat or kneel on all fours. The effort of bearing down (:kannu) to push the child out is described by many women as similar to the motions of defecation. At the time of birth a woman helper gets behind the mother and with her knee or hands presses against the mother's rectum. If this is not done women say the child may come out "where we defecate" and the mother will die.

As soon as the child is born the midwife (or woman in charge) rubs the mother's stomach with oil and ties waist cloth very tight to make the placenta (: sal) come out³⁸. Women believe that when the afterbirth is not expelled, it travels toward the heart causing the mother to swell up and die. There are several methods to aid in the delivery of the placenta: the woman may hang by her arms from a stair railing or low rafter; she may be told to squat on two unglazed bricks over a basin of steaming hot water; or she may be made to swallow some of her own hair rubbed in cow dung. This latter technique, intended to make the woman vomit and thus exert down to expell the placenta, is also used occasionally to make the woman exert during the final stages of a prolonged delivery. Once the afterbirth has been expelled the mother is made to sit down immediately and stretch out her legs "or else the path through

which the baby comes out becomes big and there'll be the risk that the intestine (:andra) and stomach (:bhuri) may come out also."

Women try and face either east or west so the child will be born facing an auspicious direction rather than towards the north or south which are associated with death:

When the child is born most informants agree that it may be seen by the mother. But never can it be shown to the father until a vyotish (:astrologer) has been consulted to determine whether the child has been born under a mulh (:an unlucky astrological sign) dangerous to its father. In such cases the child may simply have to be concealed for a few days from the father, or it may have to be removed from its parent's house altogether and raised by others until the dangerous period has passed. Such unfavorable mulh are rare and some informants admitted that they had not bothered to consult a vyotish before looking at their child. The following account is a case where the mother's death was blamed on the child's mulh by some members of the family. I quote it at length because it gives a sense of the procedures and reactions to a complicated delivery when no doctors or hospitals are available. The speaker is recounting the birth of her brother when she was seven years old:

I was playing about when I saw a huge snake in the kitchen. I shouted and my father came to see if it was true. Then he said that a snake should not be taken out through the door, so he took a stick and flung it out the window into the agan (:courtyard). They say that when a snake enters a house then there will be evil days.

About a week after that snake had entered, they say that mother went down to milk the cow and our buffalo gored her with its horn. Her blouse was ripped from here to here and there were wounds all over her body. She was on her hands and knees like this calling my name. I was afraid when I saw her and went to get father. Father said that she shouldn't have gone to milk the cow - that he would have done it. He scolded mother. Then he caught her by the arms and took her up to the house. She was ill for about a week with fever and there was fear that something might happen to the baby that was inside her. There was some medicine that had been brought from the city and she put that on.

When her labor pains began, father was out in the fields. It was time for harvesting the rice. Mother had got up in the morning and swept the

kitchen, milked the cow and gone to cut grass for the cow. She told me to do puja, so I went to the spring to fetch some clean water for puja. And while I was gone mother began her labor pains with no one there except my ten year-old cousin Leela. Leela came running saying my mother was in labor.

Mother said it was true. She had only cooked rice for us children and she said she wouldn't have time to cook the tarkari as well. She told me to go and call hazur ama (:grandmother). When hazur ama came she said not to mind the tarkari. We children could eat meat left over from Desai.

Then hazur ama held my mother's hand and sat there. Our dhai ama, that ghartini woman whom we had with us, held her from the other side. Mother said she was in great pain. They held her from behind around the waist. When a baby is being born then there's pressure at the rectum because the baby wants to come out.

I was there with my mother. I was peeping around to see what it was they did to mother and to see if the baby was going to be a boy or a girl. Actually the grown-ups tell you to go outside, but we do not listen to them and we go and look and they let us stay.

Then mother had the baby. She gave birth to a bhai (:younger brother). The mother has to keep the baby covered with the phariya (cotton sari). When mother lifted her phariya and looked, she said the baby looked just like Sri Krishna. But she should not have done that. As soon as the baby comes, then a gyotish has to be consulted about whether the baby has come under the mulh of the father or the mother. Only when this has been done can the baby be seen by others. But my mother felt like looking. She was happy because a son had been born. I covered the baby because I knew she was not supposed to look.

Then father went to consult the family priest. He was told that there was nothing to fear and that my father was very fortunate as he now had two sons and a daughter. Our priest said it would be a very happy family.

But when father came back, he was told that the delivery had been very hard on mother. She couldn't

see anything. She said a cloud covered her eyes and she couldn't recognize any of us. Someone who knew about such things came and felt her pulse. She had not eaten anything since the morning, so they cooked a little ghee, milk and misri together and fed it to her. But she threw it all up. And then she began to throw fits.

The dhai ama was asked to take the child and cut the nal (:umbilical cord). It was cut and bhai was separated from mother. But really, you shouldn't cut the cord until the afterbirth (:sal) has come out. And now the afterbirth was in the womb and the baby was outside. The afterbirth must come out quickly. If it remains inside for a long time then it expands and goes to the heart and the woman dies. In those days there were no hospitals. If a hospital had been there, then the doctor would have taken out the afterbirth right away and she would have lived. When the afterbirth did not come for hours they hung a kuto (:mattock) from the umbilical cord...since it is supposed to be something heavy. But even then the afterbirth did not fall out.

Mother was told to eat some rice, but she refused. She was lying down like this and my grannie put a pillow under her to make her more comfortable. And she passed away there.

Our youngest grandfather was there and even though he was not to touch mother as she was in sutak (:birth pollution) he felt her nose. It was very cold and he said she wouldn't live. I fainted then. Grandmother and everyone began to cry and wail because mother was dead. I remember they had to throw her from the third story window out onto the angan because she had died in the house and they could not let her be carried out through the door.

Grandfather said that the baby was to be taken away and given to someone to be brought up. They said it was an ama-tokuwa (lit:one who bites the mother). They said he had eaten up his mother. The baby had been born in the mulh, even though the jyotish hadn't said anything about it. So they said the baby should be taken and given into the house of the lato (:man who is deaf and dumb; cretin).

But grandmother was very fond of sons. She said that if the baby had been a daughter then they could have given her away, but it was a son so he would drink the milk of her eldest daughter-in-law who was still nursing. She argued that mother's time had been up so she died; the baby hadn't eaten her!

So our Thulo Ama (:father's elder brother's wife) kept the baby...and father gave her plenty of buffalo milk, chura and sugar...so she could produce milk for his son. Our Aunt kept the baby for thirteen days and then Phupu (:father's elder sister) came for Tihar. She said that she would take her brother's son and raise it. "I have lost a son and I am a widow. I will take this baby." She had given birth to a son, but it died. She said that this way she would get over the sorrow of her dead son.

So our phupu raised him. Father sent her a goat from the terai, one that gave a lot of milk for the baby. He sent grains, maize and wheat and some money for school fees. But Phupu herself spent a lot. She went to a lot of trouble. She used to cook litho (:a rice flour and ghee paste mixed with water or milk and heated) for him. When the baby cried, he pulled at Phupu's breasts and they say that real milk came from them even though she had not nursed for seven years.

The Sutak Period

Sutak (from the sanscrit sutaka:birth) refers to the specific ritual pollution which attaches to a woman, her husband and (in varying degrees), all her affinal relatives after she has given birth. This period is also called kuna ma (lit: in a corner) or sutkeri hunda though the latter term extends beyond the formal ten days of sutak impurity to the entire period of the mother's recovery. Sutkeri refers of the new mother herself.

Conceptually, sutak pollution for the mother is the same as menstrual pollution, but greater in intensity. As one informant explained, "The residue of menstrual blood that has not come for ten months now comes with the baby, so it is like all those months of na chune compressed into ten days." The sutkeri spends most of this period resting on her mattress of heaped straw (mattresses or quilts of cotton would be permanently polluted by her) in a dark room with as few doors and windows as possible. A small knife is put under her pillow as protection against supernatural beings

which may try to harm her or the child. The infant may not be exposed to sun-light for ritual reasons, but the closed room is also preferred for the mother because she is especially vulnerable to drafts after child-birth. If she is not kept warm at this time she is liable to cramps, and swelling so she will dress warmly and wear slippers around even inside the house.

The sutkeri is untouchable to all, but especially to men during this period. Women of course do touch her when they come to massage her with oil or help her walk if she is weak etc. But such women helpers must wash their body, hair and change to clean clothes before eating or touching a man. The infant itself is not polluted and may be handled and fondled by men and women alike. But it must be placed on the neutralizing earth or gobar floor by the mother and not handed directly.

Sutak as it affects the husband and members of his household is very different from that which affects the sutkeri herself. Other household members are not considered polluting to touch and may move freely in the community. There are no restrictions on food as there are during death pollution. They are restricted however from worshipping family or temple gods and from having bartamans or weddings etc. in the family. Sutak lagne and the consequent ban on such celebrations takes effect only after the umbilical cord is cut. Hence sometimes if a big wedding is underway which would be expensive to postpone, the cord is not cut. Instead the afterbirth is put in a brass vessel and covered (to keep away flies and reduce the bad odor) and the cord cut only after the crucial rituals are complete in the wedding. Another case where the cord is not cut is when an illegitimate infant is secretly abandoned. As long as the umbilical cord is intact the infant is considered to be casteless and can assume the caste of whoever takes it in and cuts the cord.

There is some uncertainty about when the umbilical cord (:nal) should be cut. Although it is more orthodox to sever it within an hour or two of birth most women wait at least until the next day and sometimes longer to do so. "It is said in the sastar that we shouldn't keep the nal for five-six days for our convenience like we usually do. It is said that it has to be severed within two hours of birth or it might be jutho." Unless the mother is too ill or weak, she herself will cut the cord because the task is highly polluting and she is already in a state of pollution. The cord will be tied off at the base with kancho dago (:new undyed string) and cut about five or six inches long. Nowadays a razor blade is preferred, but a small knife or even khukuri or sickle may be used. A mohar coin or a supari is placed under the cord as it is cut and within a few days women say it gets black, dries up and falls off. Some keep a piece of the cord sewn into a small amulet (:buti) around a male child's neck as protection.³⁹

Again, if she is able, the mother herself will take the carefully concealed placenta (:sāl) outside to some corner of the courtyard or kitchen garden or perhaps to the edge of a nearby field and bury it. Like menstrual blood, the placenta, if seen by a bokshi, leaves both the mother and the child vulnerable to witchcraft. It is also a common belief that a child will return to the place where the sāl is buried, so sometimes when a child hangs around the kitchen area too much, he will be teased and asked if he thinks his sāl is buried there. Women believe that the distance the sāl is buried from the house is proportional to the time it will take them to conceive again. So if they want to have more children soon, they will bury it in the courtyard and if they wish to practise "family planning", they will take it to a far-off field. After the sal is buried a leaf plate containing a votive light (:diyo batti) is placed over the spot.

Women are apt to be rather disheveled and not very clean during the sutak period. In fact sutakari justo (:like a sutkeri) is used as a synonym for sloppy, lazy and unkempt. The sutkeri is not supposed to comb her hair or go to the dhara to bathe. Further-

"A sutkeri (:new mother) rubs herself with oil in the morning sun." (Photo by Alice Wygant).



more, because of the belief that the sutkeri is especially vulnerable to chill and damp, even sponge baths with water carried up by others are avoided by many women who feel it risky to be at all wet. Instead, heated oil is applied lavishly to head and body. A fire or pot of coals is usually kept going for warmth. Some women throw juwano (:medical herb; Ligusticum ajowan), sop (:aniseed) and methi (:fenugreek) seeds into the fire and stand over the fire allowing the smoke to ease soreness in the vagina and "keep the womb from falling out" (:pukaune na niskine; ang na niskine). A more common method of the same juwano, sop and methi seeds in an oil soaked cloth which is heated over the fire and then placed in the vagina itself.

Although the sutkeri is generally unkempt, her breasts are washed with warm water soon after delivery because this practice is said to start the milk flowing. Some women say that they begin to nurse immediately. But many say that milk came for them only on the third day - when it is traditionally supposed to come. Rich food and juwano ko jhol (:soup made from a medicinal herb, Ligusticum najowan) are said to be effective in making milk come. Another recipe for the same purpose is to mix ghee and dried ginger in hot water; then molasses is added and the whole mixture is brought to a boil and given hot to the mother to drink. Many women said no meat or blood of any kind should be taken for the first three days after the birth or the woman's bleeding will increase. But then, in contrast, one woman recommended taking rakti (:blood obtained from a goat after its head has been cut-off and the blood allowed to congeal) to make bleeding stop.

In the meantime until the milk has come, the hungry infant may be fed ghee, either hot or congealed with sugar, misri pani, cow milk (buffalo milk is thought to induce diarrhea because it is too rich) and litho (:rice flour and ghee paste mixed with hot water or milk). Since the preparation and storage of this initial food is rather casual, this interval before breast milk comes may be a dangerous one for the new born infant. Once the child begins to nurse he usually is given no supplementary foods (except medicines or, among those able to afford it, a nutrient supplement) until the fifth or sixth month when his system has developed some measure of immunity.

Unlike its mother, the new born infant can be, and is bathed, usually in warm water soon after birth. During the first ten days, and if possible until the six month pasne ceremony, a child should be oiled daily. During sutak the child should be given no stitched clothes to wear. It is covered instead with pieces of old saris while the damai (member of tailor caste) sits outside sewing up small bhotos (:sleeveless shirts with strings to tie at the shoulders) and at least one cap with a tiny cape down to the back to keep drafts off the child's neck. These clothes will be put on after the naming ceremony on the eleventh day. It is thought to be

bad luck to make clothes from new cloth until a child has had his pasne, so household members and neighbors are expected to contribute cast-off clothing for the infant's diapers (:talo) and his tiny mattress and pillow.

On the evening of the sixth day after birth (:Chaitom), a pen, book and a lamp are placed in the room where the baby sleeps. The lamp is kept burning all night for it is believed that on this night Bhabhi, the goddess of fate, comes and writes the child's fortune on its forehead and the goddess must have light and implements so she will write out a long future for the child. Nepalis always gesture toward their forehead when they speak of their personal fate or destiny and are fond of the saying. "Bhadhi le likeko, kasle metnu sakincha?" (Who can erase what Bhabhi has written?).

Nuharan: Naming & Purification Ceremony.

Finally on the morning of the eleventh day the sutkeri can go and bathe, wash her hair, clothes and bedding at the spring to prepare herself for the nuharan ceremony when her baby will be named and she and the household will be purified. The straw on which she has slept is burnt. It would be sinful to allow a cow to eat such straw or others to accidentally touch it - and the blood stains on it would allow a bokshi to attack.

The child's father - or if the father is absent, a classificatory father - must be present on this day to claim the child and give it his thar and gotra. He must also bathe on the morning of the ceremony and put on a new sacred thread. In cases where the child is illegitimate, the failure to produce a father for the nuharan condemns both the child and the mother to be henceforth untouchable. If the child's true parentage is unknown, no chance can be taken and the worst is assumed.

The family priest comes and inside the house on the ground floor he prepares a rekhi (:auspicious astrological design made with rice flour) on an area which has been freshly spread with gobar (:cow dung) by one of the women. He sets leaf dishes of uncooked rice (some of which was beneath the lamp on Chaitom) and brass pots full of water, etc. down on the design to represent the gods that are being called to bless the child. Then, piling firewood in a neat pyre in the center, he begins to do a hom (:vedic worship of fire) ceremony chanting sanskrit and making offerings into the fire. He is assisted by the child's father who has drunk gaut (:cow urine with purifying powers) and done a godan (gift to a Brahman of one mohar and five paisa representing a cow and a calf) to purify himself. At one point in the hom ceremony the priest asks the exact time of the birth and then consults his patro (:astrological almanac) for the child's religious name.⁴⁰

The father then tells the priest his thar and gotra and gives him tika. Then the Brahman writes the child's name with yellow kesari (:saffron) paste on a pipal leaf which is placed on the child's head, and the Brahman whispers the child's name into its ear three times. The Brahman then holds the child over the hom fire and bounces it in the air three times. This is said to make the child brave - but also serves to purify it through association with the fire. Now the child may be taken outside and given its first view of the sun. The child's mother or grandmother covers the child with a shawl and carries it outside placing its feet on the ground and then uncovering it to the sunlight. Black gajal will be put around the child's eyes and if it is a girl her ears may be pierced.

Next the Brahman gives tika to the baby, the father and other members of the family. He then mixes panch amrita (:a mixture of ghee, curds, cow urine, dung and honey with great purifying powers) which is first offered to the family gods to purify them and then given to each family member to drink. Some is sprinkled around the circumference of the house and on the family. The family members, thus purified, come to the Brahman to have the protective yellow rakya bandan strings tied to their wrists. The child's father must then give tika and dakshina (:small gift of money to a ritually honored person) to the daughters of the house. Unless they feel it is unlucky because they have lost so many children or cannot afford the vyotish's fee, the family will have the child's cina (:horoscope) written out on that day.

There is a slight variation in the purification rites which are done for the sutkeri woman during the nuharan. If the family is large and there are enough other women to do the cooking and carrying of water, then the new mother may be left in a state of mild pollution similar to that on the fourth day of menstruation. She is touchable and may comb her hair and move about freely, but still may not cook or touch water which others will drink. If the woman is to be given this extra "vacation" then she merely bathes, drinks gaut and is sprinkled with panch amrita at the nuharan. After another eleven days, on the twenty-second day after delivery, she becomes fully purified by bathing again and doing a simple godan puja to a Brahman and receiving tika from him. This is considered more orthodox and prestigious, but in families short on female labor, the godan is done on the eleventh day and the new mother is able to cook and carry water thenceforth.

Even in the case of a miscarriage or a still-born child the sutak period must still be observed. If the foetus is lost before the fifth or sixth month when the sas enters then the woman must remain apart for seven days as if it were only a lightly longer menstrual period. On the eighth day after her bath she must do godan to a Brahman and then she is choko (:pure) again. If the child is lost after the fifth month or still-born, then the woman must observe the full ten days. On the eleventh day when the

nuharan would have taken place a Brahman is called to do a hom ceremony and give gaut to the woman and her family and sprinkle it around the house. In such a case the family will be observing both birth and death pollution simultaneously for the child. The latter observances will be described below.

The initial month after childbirth must be spent in the husband's house. At least once during that period the new mother must be given sutkeri ko ausadi (:medicine for the sutkeri). A long list of herbs and expensive⁴¹ spices are fried in ghee; the milk is added and the mixture is allowed to boil slowly for several hours. Some of the oil that comes to the top is drunk by the sutkeri and the rest is rubbed into her body. A large share of the remaining sweet mixture is given to her and the rest divided up among the family. This medicine is to bind or close up the mother's body after childbirth (jeu badhne lai). The sutkeri will be fed rice three times a day instead of the usual twice and she will be given as much meat (goat or fish) as can be afforded. Pan (betel wrapped in leaves) will be given to "clean out the blood" and a special rich sweet called gund pac.

If she and the infant are strong enough to travel after the first month, they go to stay at least one month and often several in the woman's maiti. This is viewed by women as one of the great rewards of childbirth. In the maiti, sutkeri ko ausadi is given again along with other rich foods cooked in as much ghee as the family can muster. The sutkeri spends many hours gam thapne or "soaking up the sun", covered with oil and often stripped bare to the waist. For now that she has borne at least one child, there is no shame in exposing her breasts. The infant is also placed in the sun because it is believed that it needs to be dried and warmed after its many months in the watery womb. Small collapsible tripods are made from sticks and hung with clothes to give the baby's face shade or else a doko is turned on its side and covered with cloth and the baby placed inside. Sometimes of course the doko has just been used to carry manure to the fields and may be far from clean. Also flies flock over the infant's oil-covered body and are largely ignored by adults.

When a woman who has had her first child returns to her ghar her father must send a full set of new bedding for the mother and child. Also, once his daughter has produced a child, the father can take rice at her ghar, whereas before if he were orthodox he would be reluctant to even accept a glass of water in her marital village.

Pasne: First Rice

Just as female infants were said to move in the fifth month of pregnancy rather than the sixth, so girl babies are ready for their pasne or first rice feeding ceremony in the fifth month, one month earlier than boys. This is said to be because girls develop faster,

but may also be due to the fact that females are usually connected with odd numbers and males with even in Hindu symbology. The pasne ceremony is simple. A brahman or jyotish is asked to consult his patro and name an auspicious day and hour for the child to be fed his first rice. Sometimes the family cooks khir (: a rich rice pudding) which is offered to the god in a public temple and then fed to the child and its relatives. Often however, khir or an ordinary rice meal is cooked and given at home. The child, dressed in new yellow clothes, is fed his first rice, usually on a one mohar coin by the senior male member of his father's household and than all the others "whom the child must respect" (: manne manche) must feed him in order of rank. Then, when the child's paternal relatives have finished, his mama (:mother's brother) and any other maternal relatives who have been called also feed him. Everyone who feeds the child must give it a gift of either money or new clothes and then they are feasted in return by the child's parents.

Women say that around the time of pasne, but sometimes several months later, the child's first teeth appear. After the first teeth have come, if a child dies he will be cremated with the uninitiated (karma na caleko) intermediate status rites of any unmarried girl or any boy who has not yet had his bartaman. The child's mother and father will observe five days of death pollution (rather than thirteen days as for a karma caleko adult) and the rest of the paternal relatives will observe only three days.

For a foetus, after the sas has entered or an infant before the coming of the baby teeth, there is a special simplified funeral rite. No distinction seems to be made between a premature still-born child and a child who has lived several months. Such infants are not cremated but buried. A hole is dug and a dish of milk is placed in the bottom and buried with the child or foetus. Then, five days afterwards milk is again brought and placed over the grave and a set of new clothes is made and given as dān to a brahman child of the same sex as the deceased. During the five days the child's mother and father eat only once a day avoiding salt or oil and may not do puja. Other paternal relatives eat only one meal on the first day and after bathing the next day are again choko.

Campbell⁴² notes that honored saints and smallpox victims who are said to be possessed by the goddess Sitala are also, like infants, buried rather than cremated. He suggests that all three of these categories are in some way "outside" the community for whom normal Hindu ritual applies. Both the achieved yogi and the smallpox victim have for different reasons transcended the normal human state. They no longer need the symbolic final purification of the body which the fire brings. Infants also do not need this purification because they have not yet fully entered the community. It is believed significant that Nepali Brahman-Chetri society chooses the appearance of the teeth, which conceptually if not always physi-

cally, occurs simultaneously with the feeding of the first rice, as the entry point. For rice itself is the central currency of the Hindu system of accounting purity and pollution. As soon as the child eats bhat (:cooked rice) he becomes vulnerable to and the source of food pollution (:jutho) and begins to need the ritual mechanisms of purification which society provides.

Initially the link which nursing establishes between mother and child seems to protect the child from pollution. Mother's milk is of course a choko or pure food and informants often explained that infant defecation and urine does not pollute as much as that of adults because the infant's only food is its mother's milk. Women often explained that mothers give milk because "God would not create a child without providing his food". This expresses the sense of biological dependence between the mother and her nursing infant which causes them to be perceived as an organic and hence ritual unit. We recall that a menstruating woman does not pollute the nursing child. But with the eating of his first rice, the nursing link begins to weaken and the child begins to be perceived as a separate ritual entity. The connection between the cessation of nursing and the achievement of full ritual being is further strengthened by the chewar or hair cutting ceremony. The chewar is part of the bartaman ceremony where as we said, the male child becomes a full status adult member of his caste community. For the chewar the boy must sit in his mother's lap while his hair is cut, but facing away from her where he cannot nurse as he did as a child.

Chetri-Brahman Concepts of Child Development

From family observations and casual discussions with informants it would seem that village Brahmans and Chetris have a very relaxed attitude about child development and especially about their role in it as adults and parents. Infants and young pre-school children are classified according to their level of physical and mental development into several often overlapping categories and it is believed that all normal children will pass at their own speed through these stages.

The first level, thangne ko baccha or kakhe ko baccha, is said to last usually five or six months. This is literally the "diaper" or "lap" baby. The kakhe baccha moves around very little (and is therefore easier to watch and content to stay in a basket crib suspended from the porch) but should eventually be able to smile, recognise close family members and grab objects. Then comes the bameh sarne or crawling stage which overlaps with the tuku tuku hirne or toddler stage. The tuku tuku hirne or early walking may begin anywhere from ten months to two years. During the toddler stage boli phutiyo and then tote boli or imitative sounds and baby talk, begins. Hurrinu or kudhne are used to describe a child who can walk with some assurance, and finally somewhere between the

age of five and six the child should achieve the prasasta bolne stage where it can converse freely and be understood.⁴³

This time-table is obviously very flexible and little concern is expressed if a child is months, sometimes even years, late in reaching a given stage. There is little competition between parents comparing the achievements of their offspring. Growing up is seen as a natural almost organic process which goes at its own pace more or less regardless of what the child's parents do. This attitude begins with the child's early achievements in motor control and often continues throughout his experience with formal education.

This is not to say the Brahman-Chettri parents take no interest in their developing offspring. It is true that young fathers in a joint household tend to be detached from the child in public situations out of respect for their own father who as head of the household is still the categorical "father" of the child⁴⁴. But grandfather, grandmother, mother et al will spend hours playing "give and take"⁴⁵ and later teaching the child to namaste etc. The child's early attempts at walking and tote boli (especially if it innocently repeats abusive or obscene language) bring warm response from the family. In fact tiny Brahman-Chettri girls probably reach the peak of their dancing careers when they can barely walk and have not yet learned to feel the laj or shame proper to the female sex. However this interaction with the child is seen less as a conscious effort to teach and develop the child than as a pleasureable family pastime. In fact, after the child achieves a certain level of skill in speaking and moving, he may find to his frustration that since he is no longer so amusing, less attention is paid to him.

Parents are held responsible for the child's development in certain areas. Cleanliness and eating habits - both of which are heavily loaded with ritual significance in Hindu culture - are two such areas which will be discussed subsequently. A third rather vague category, is bāni or habits, which includes eating and cleanliness but goes beyond to moral qualities such as honesty, chastity for girls respectfulness to elders and religious reverence. These are believed to be affected by parents and home environment. For children are believed to learn largely through imitation (:nakal garnu) of those around them. Often if a child steals adults will remark that it is because someone at home steals. Hence the available models are felt to effect the child's behavior - but the influence of adults in the home for good or for bad tends to be perceived as largely passive.

Direct discipline and confrontation especially when younger children misbehave seems to be avoided - though of course it does occur. This avoidance is especially apparent with the frequently witnessed temper tantrums thrown by young children when their wishes are not gratified. When adults cannot or will not meet a

child's demands (usually for food or spending money), they tend to ignore them. And when the child's nagging escalates to screaming, weeping and even pounding fists, the adult will either continue to ignore it or else tease and laugh at the child's display. The tendency is not to take the child seriously and get angry, but to remain detached and wait for the child's temper to subside.

Physical punishment is of course, given, but it is sporadic in the families I have observed and usually given only to children over nine or ten years old. Instead, threats are frequent. They begin, in fact, as one of the games played with small babies where the adult raises his hand to strike but follows through with only a gentle strike saying in a baby voice, "Pai garchu" (:I'll hit you). As the child gets older, he slowly learns that the raised hand sometimes means business - but not very often. Along with this, the decision to discipline certain types of behavior frequently appeared to be inconsistent. For example, in one family I have observed for two years, both parents were always quite casual if their son stole small sums of money or food from the locked cabinet (the lock of which he'd learned to pick) or from the pockets of his father's (or the visiting anthropologist's) clothes. They might scold him or grumble that he'd left none of the sweets or coins for his little sister, but they never confronted him with the idea of theft - even though both adults hold personal honesty in high esteem. Then one day recently when a rupee was found missing from the knot in my sari and the boy admitted taking it, he received a beating and an angry lecture from his father. The father had decided that the boy was no longer a child (he is twelve) and that if he continued to take things like that stealing would become a habit.

Eating Habits and Personal Hygiene

After the pasne ceremony, the child's diet of mother's milk begins to be supplemented with rice, cow's or diluted buffalo's milk and any vegetable tarkari which the family is eating. Even though adults eat in strict order or rank, children are always fed first. Up to the age of three or four, children are fed by their mother or some other adult women. If he is old enough to sit properly, the child is given his own pirka (:wooden plank seat) and usually eats every meal in the same place on the mud and gobar plastered floor by the cooking fire. Small children are fed in their mother's lap. The mother first kneads the food with her hands reducing any large pieces of vegetable to bite size and then blows on it to cool it. In families where economics permit variety, the child is

"A woman relaxing in her maiti (:parent's home) with her three month old baby." (Photo by Alice Wygant).



asked what it prefers - usually the choice is between rice with milk or with tarkari and dal. Usually the child is coaxed to take some of both, but never forced to eat what he doesn't want. Often, the head of the household may sit down to eat while the child is still being fed and, as a gesture of affection, he may give some of the tarkari from his plate to the child. Such food taken from the plate of another after they have begun to eat is considered jutho or polluted and would not be eaten by other adults (except a man's wife, as a sign of her respect for him), but the rules of food pollution are very lenient for young children. They can take food freely from almost anyone, but especially someone in the ritually superior position of the father. Until their adult teeth come in, they may even take food from an untouchable with no harm to their caste status - though this is not encouraged by parents. Several women interviewed remember with special pleasure sneaking to a damai or sarki (both untouchable castes) house to be given sweet foods. Even after adult teeth have come in, a relative leniency prevails until a boy's bartaman initiation or a girl's marriage. Some very strict and proper Chetri and Brahman women remember eating buffalo meat and even drinking a little rakshi at the houses of Newari friends when they were young. They are also allowed to take the ritually relevant foods (dāl and bhāt) from the people of castes lower than themselves as long as they are not untouchable (: pani na chalne). Once marriage or bartaman takes place however, these foods may be taken only from people of equal or higher caste.

Parents know that it is difficult for infants and children to go with only two full meals a day as adults do. So rice and some tarkari from each meal is set aside in a dish usually covered and weighted down with a brick so that cats or rats won't disturb it. In the morning rice called basi tasi from the previous meal is heated with some milk or left-over dal and fed to children under four years. If the family can afford it, hot milk or milky sweet tea perhaps with a handful of chiura (pounded rice) or four or five glucose biscuits or even store-bought bread thrown in will be given instead. Some rice from the mid-morning meal is also saved in the same way for the afternoon snack or kaja. Roasted soybeans, dal and popped corn are also given to children at that time.

Nevertheless children whine and tease for food constantly throughout the day and before each meal. This is permitted, parents say, up until the child is eight or nine (though I have observed it in children twelve and thirteen years old) and what is more, it is very often rewarded. Likewise, children who go to school tease their parents for money to spend on sweets or tea - especially those who go to school early before the morning rice meal. I have observed many scenes of children sulking and refusing to go to school at all until they had "extorted" a few paisa from their already hard-pressed parents.

Older children (above five years) are often asked to taste the tarkari or achar that the women are making and report if it is too hot or has enough salt, etc., because the cook cannot taste it herself without polluting it. Whenever the family has tea or some special food, a generous portion is given to children. And whenever a family member goes to town or a relative (especially a returning daughter or daughter-in-law) comes to visit, they are expected to bring some biscuits, fruits, or sweets to the children of the household. Such treats are called pāpā and no child under the age of eight is too shy to beg for them. I have not observed the denial of such foods used as a punishment -- though it is often used as a threat. Only in cases where sweet rich foods are thought to aggravate a child's illness will they be denied. Throughout Brahman-Chetritic culture, the feeding of rich special foods is a cipher for affection and concern,⁴⁶ and this is especially true for children. A fat child -- like a plump woman -- is not only considered healthy and attractive, but beloved.

From the moment they are given their first rice, children begin to be taught the complex pollution concepts which surround the act of eating in Brahmin-Chettri homes. Infants' hands and faces are washed whenever they have eaten dāl bhāt -- though not always when they have eaten chokho foods even if they are just as messy. As soon as they can walk, toddlers are taught to go directly to have their hands washed by an adult after eating and not to touch anything or anyone with their jutho hands on the way. Reactions are strong when a child makes a mistake and praise lavish when he learns to clean himself, so that by the time they are four most children are deeply ingrained with proper ritual food pollution behavior. Non-ritual types of impurity, however, are hardly noticed. If food falls on the floor in the house or even on the ground outside, children pick it up and continue eating and are encouraged to do so by their parents. Children are also allowed to eat the bits of cut fruits or sweet breads that are left as offerings for the gods at indoor and outdoor shrines. Flies are also tolerated or swept away ineffectually when they cluster on a sweet which the child is eating. Children also eat unripe fruits and berries and over-ripe fruits which have fallen to the ground. Parents show little sympathy when the child complains of a stomach ache after gorging on such fruits, but no specific attempt is made to stop them.

Traditionally, children should not be bathed on Sundays and Wednesdays and never after dark in the evenings because to do so might attract bad spirits (pichas and bhuts) and ill-fortune to the child. If the child is ill or the day too cold the bath will be postponed -- or if there is time, water will be heated. Soap is still somewhat a luxury, but is more and more common. Scrubbing is done with the firm strokes of adult hands. After bathing, the child is dried off and placed in the sun and rubbed with oil. A little oil is poured in each ear (the child may become deaf or have ear

aches if this is not done) and later after the hair is dry, it too is oiled. Women believe that hair which is not regularly oiled will not be lustrous and black, but wispy and reddish-brown like the foreigners who don't oil their hair. Lice are removed by hand and the process is sort of a game which mother and child enjoy. Heavy infestation or a rash may result in shaving the child's head entirely. Little girl's hair is usually kept short in the belief that it will later grown in thicker if this is done.

Some mothers also put black gajal around their infant's eyes every day believing that this will make the child's eyes bigger when he grows up. Children are always made up for visits to town or relatives. Even twelve year old boys dab on some of their mother's face cream and perhaps some powder (both believed to make the complexion lighter) - though boys do stop short of lipstick and gajal eye liner. Children brush their teeth the same way adults do - though less regularly - with a finger and some ash from the fireplace.

Toilet training, like eating habits, is important in terms of ritual purity, yet it seems to be viewed much more casually. Rags (:talo) are placed underneath infants as diapers and often, if they are soiled only with urine, they are not washed, but simply placed in the sun to dry. This practice may partially account for the frequent rashes on infants. As the child becomes mobile he is allowed to crawl around without pants or in the cold weather with pants that open up the back. This makes cleaning up easier. Training begins casually around the crawling stage with taking the child outside or to a kopara in the mornings and after meals and naps and encouraging him with "ssiss" sounds and praise. Most women seem to tolerate accidents and even expect them at least until the child is two or more. By then, he is expected to be able to make his need known in baby language⁴⁷, so that an adult or older child can take him outside or to a cemented drain or kopara upstairs. Eventually he will learn to go outside by himself during the day, but will have to call for someone to wash him off until he is four or five. If a young child is left unclean after defecation, it is taken as proof of the family's - especially the mother's - slovenly habits. Children use the kitchen garden, the pathways near the house and even the courtyard for defecation and are not expected to go out to the fields like adults. Even in rare families where an outhouse is available, children are not particularly encouraged to use it - so the attempt at preventing fecal borne diseases is greatly vitiated. My informants were all unaware of the fact that illness, such as the ever-present worms, were spread through feces.

Village Concepts of Child Illness and Home Treatment

The concepts which Brahman-Chetri villagers hold about child health are but part of a larger matrix of theories about illness

and curing, and not surprisingly they cannot be fully understood apart from them. These complex multi-layered concepts are described and analysed in Linda Stone's article "Concepts of Illness and Curing in a Central Nepal Village". In this paper I have attempted to give only some indication of how the more common childhood ailments are dealt with in the home by non-specialists.

From my observations, there seem to be roughly two overlapping categories in the village concepts of health which we might for discussion purposes call the "natural" and the "supernatural".⁴⁸ Natural refers here to ailments due to biological failure and usually amenable to cure through western or ayurvedic medicine or local village "common sense". Supernatural refers to the effects of sorcery, and attacks by evil spirits⁴⁹ and even by gods (:devtas) Such illnesses like that recorded on page 19 of this report, must be dealt with through the medicines and rituals of dhamis, jhankris and gubhajyus or through domestic and community worship of the devta or spirit in question. These categories however, are by no means mutually exclusive. An illness can be diagnosed as the result of both natural and supernatural causes at the same time. This often happens when much respected western medicine does not produce an immediate cure or even any cure at all. Villagers say then that a bokshi has cast a spell on the patient which prevents the western medicine from working (:ausadi rokyo), a jhankri or gubhajyu must be consulted who will perform the rituals and advise on the sacrifices etc necessary to counteract the bokshi's spell and allow the western medicine to do its work. In short, since the systems involved in the maintenance of health overlap each other, it is not surprising that the forms of treatment should also.

"Common sense" was mentioned above, along with western and ayurvedic medicine for dealing with illnesses in the natural realm. It refers here specifically to the traditional, non-specialist villager's home treatment of such sickness. The following are some of the common sense treatments which women informants said they follow for the usual illnesses of infants and children. Many of them center on food and theories of internal heating and cooling properties of various foods. For example, it is a common thing for boiled water which a doctor or health worker might recommend giving to a sick child to be equated with hot water. Villagers are apt to think that the temperature of the water, rather than the fact that the amoebic impurities have been killed, is the significant factor.

If a child is ciso or chilled from lying or sitting on damp ground, he should be rubbed with warm oil near a fire and given a heated brick wrapped in cloth to sleep with at night.

Joro or fever is treated by giving the child only rice and milk or possibly rahar or mung dāl - but never kalo or black dāl.

Eggs must not be given and amilo, (:sour) piro (:hot, spicy) and guilo (:sweet) foods are also avoided, as they all have heating properties. Nothing was mentioned about the necessity of feeding liquids, but on questioning, informants said a little hot water or milk could be given. The child should also be kept warm with clothes and quilts in a draft free room. Fever of course, is often combined with other symptoms, so it is a very unclear category. But in a survey⁵⁰ I conducted in my village, the third most common remembered cause of death for children was fever. If typhoid (three victims) is included, it accounts for ten deaths.

For ruga-khoki or cold and cough, once again amilo and piro foods are avoided. But gulio foods, if they are hot and cooked like tea are beneficial. Na pakeko gulio or uncooked sweet foods (such as hard candies) are not good. Kalo dāl (:black lentils) is excellent for colds just as it is bad for fevers - because of its heating properties. The child should be dressed warmly with his neck and stomach wrapped. Children are taught to clean the mucus from their noses with their fingers, but they and their mothers who often do it for them, are very casual about where they wipe their hands of the germ-filled mucus. The idea that coughing spreads the disease and thus should be covered seems largely unknown. Lahare khoki or whooping cough is in the category of such diseases as T.B. (:chayarog), tetanus (:dhanuse tankar), typhoid, diptheria (:bija gothir) pneumonia and asthma (:dam ko betha) for which there seem to be no home remedies.

Constipation or disa na hunne is believed to occur because the child's internal system is too hot. Hence, cooling foods like parsi (:pumpkin), amala (:a green berry) and any rasilo (:wet, juicy) fruits are given. Cool water, glucose and misri water are also good. Pisab rokyo or inability to urinate is treated by placing an onion on the child's navel and feeding glucose water to the child.

Diarrhea or cherne is treated by restricting water and milk in the belief that if the liquid intake is reduced, the child's stools will be less liquid. Fortunately, some say they will give hot milkless tea, because diarrhea means the child's internal system is too cool. A popular remedy for simple diarrhea or upset stomach in the village is agni kumari which can be bought from ayurvedic compounders. Agni is the vedic fire god and appropriately this sweet halva-like medicine is thought to warm the stomach and thus ease the diarrhea. Not surprisingly children love to take it. Fruit is also restricted. Many informants mentioned that teething (dānt phutinu) is often accompanied by diarrhea. More serious diarrhea or dysentary is called añ and if accompanied by blood in the stools is called añ rakat. For this jira pani (: a drink made from ground cummin seeds) or a tarkari or soup of dried karkalo (: the edible stalk and leaf of the plant Arum colocasia) is given. When severe diarrhea is also accompanied by vomiting, it is called either chadne cherne or jara banta. It may be symptomatic of

cholera or amoebic dysentary etc. The only home treatment for these symptoms seems to be to give dhai (:curds) and moi (:buttermilk). In my survey, a total of eleven children died from diarrhea in some form (au rakat, jara banta, cherne) or dehydration (sukuwa betha) which is often associated with diarrhea.

Worms (jugas: general parasitic worms; dadra: ring worm) are extremely common and are usually treated with medicine bought from town or from a local compounder. The only home remedy known was mixing ash with water and drinking the water after the ash had settled. But this is no longer used where modern medicines can be had.

For gau-khatira which refers to any rash, pimple, sore or infected cut, one should refrain from giving the child bhatmas (:soy bean), mas ko dal (:yellow lentils) meat and any piro or amilo foods unless one wished to make the pus (pip) come so that it can be more easily removed.

In discussing the next three diseases - measles, chickenpox and smallpox - we must go beyond our category of "natural illnesses". For, even though villagers say the rashes of these sicknesses may look just like ordinary khatira, they are caused by a goddess (devta ayo or devta lagyo). Hence the treatment must include not only common sense but religious observances.

Smallpox, the most deadly - but also now the least common - is called either bifer or simply Sitala after the goddess who brings the disease. In India Sitala is worshiped in many different ways - often by a whole village at once. The Brahmans and Chetris in my village said that they did puja individually when someone in the family was sick, they would either take the child - or if it was too sick, take something of the child's - and make offerings at the Sitala shrine at Pashupati which should include a live pigeon. They also do puja at home using an unbaked brick and making three separate piles of offerings on it. The sores which should erupt in five or six days should not be broken by anyone, but should be rubbed with a paste made of Indian peanuts and sandalwood.

Sitala also causes dadura (:measles) and teula (:chickenpox) and the cure for both requires domestic worship at the onset of the disease, similar to that for smallpox. For dadura the most important common sense part of the cure is to not give any oily (cillo) foods or rub the child with oil. As soon as the spots are detected, the child is placed in a dark room and covered with quilts. Four or five days later, the sores should erupt and the child covered at this time and a special mixture of bakhara ko dudh (:goat's milk), dak (:raisins) and boiyar ko gera ko bitra pati (:the inside of a berry also called gudi) must be given to the child so that all the sores "come out". A "wonder" drug (because it works in opposing ways) for these illnesses is gadh, a kind of lentil which is soaked

in water and then fed to the child. It is said not only to bring down the fever, but also to "heat up" the inside of the child's body to bring out the sores. It is believed that if all the sores don't come out at this time, the child may die. The restrictions on oil continues for one month and then a paste of barley flour (:kodo ko pito) is made and rubbed all over the body. When that is removed, the body is rubbed with sheep ghee (:bheri ko ghui) which is believed to remove the scars and finally with oil.

For teula, there is also a restriction on oil rubbed on the body and food cooked in oil. The child's mother must also refrain from oily foods (even if the child is no longer nursing) out of respect for the goddess who does not like oil. The same goat milk, raisin and berry mixture or a paste made from nim wood is made and rubbed on the sores.

Besides the "common sense" treatments listed above, most ordinary, non-specialist (certainly non-bokshi!) women know home treatments - a little curative domestic magic or jhar phukne - for the many illnesses.

Almost any woman for example, can cure a headache or other mild ailment for a child or another household member by waving a batti (:lighted lamp used for puja) three times above the affected person's head, blowing on some sesame seeds and throwing them out the door or window and taking the batti outside to the cross roads. Women also know that in the community feasts, where one must eat in the presence of many suspected bokshis, one can protect oneself by touching one's plate unobtrusively with one's foot while sitting down to eat. Food that has been touched by one's own foot is no longer a medium for transmitting the bokshi's spells. Likewise, all women know - though not all are bold enough to carry out - a method of making oneself invulnerable to the spells of any particular bokshi. If one can somehow manage to feed the suspect person even a miniscule particle of one's own feces disguised in some food, that person's most powerful mantras become henceforth nyasta (:ineffective) towards one.

Another common treatment that is done at home by family members is for a vague disorder called runche which can affect children if they touch a pregnant women or a woman who has just given birth. The foetus (after the sas has entered) or the newborn baby causes children of the opposite sex to cry and act naughty and disobedient if they touch its mother. The cure can be done only on Tuesdays and Sundays early before the crows have cried in the morning. A mixture of ground grasses (armalijhar and dubo), cow urine and cow's milk and water is prepared. Without taking off the clothes he has slept in, the child is placed under a carrying basket (:doko) and the child's mother pours the mixture over the basket. The baby's urine is placed on its lips three times while the mother says, "Tewar, tewar Aitabar; Nani ko runchi

sat daun par. Runi Rouni ja; Hansi kelni a. (Tewar, Tewar Sunday, Let baby's crying go seven villages away. Crying, fussing, go; Laughing, playing come.) Then the baby's dirty wet clothes are removed and washed without wringing. A leaf plate containing sesame seed oil along with incense and a lighted wick, is placed between the child's legs as he sits in the doorway of the house and then removed and taken with the wick burning to a crossroads.

FOOTNOTES

1/ Only males who have been initiated (karma caleko) with the sacred thread can perform sacrifice for the kul devta - the god who if pleased protects and brings good fortune to the family unit. Also it is the son's responsibility to perform austerities (kirya basne) at his father's death and the commemorative sraddha ceremony thereafter on the lunar anniversary of the death. This responsibility carries over two generations and becomes should-read:

2/ Mulki Ain (Nepali version) p. 211, Himalaya Pustak Bandar, Kathmandu, 1972 (Nepali year 2029).

3/ In more remote areas such as Nuwakot district this "fashion" had not yet affected the Brahman-Chetri community and the large majority of marriages occur before the girl has reached the legal age. Linda Stone, personal communication.

4/ A marriage and fertility survey was conducted for all the Brahman-Chetri women past menarche, who were presently members of the local patrilineal kin groups of the village. Specifically, this group of fifty-nine women includes unmarried daughters who are still members of their father's thar and gotra and married women who have become members of their husband's thar and gotra. Married daughters who have become members of their husband's thar and gotra in other villages are not included.

5/ This is consistent with the high emphasis Hinduism places on the purity of its women. Such a practice was felt to insure a virgin bride. For further discussion see Yalman's excellent article "On the Purity of Women in the Castes of Ceylon and Malabar" Journal of the Royal Anthropological Institute, Vol. 193, 1963.

6/ The average age of menarche-which is relatively late in most developing countries - has a clear correlation with nutrition level: The higher the nutrition level, the earlier is the average age of menarche.

7/ Most Brahman and Chetri farmers - especially young men still living in a joint family with their fathers - try to get a jagir or job with the government, military, schools etc. They are gone most of the time, leaving farm management to a father or brother and farm work to the wives, but the job provides a much needed source of cash income.

8/ Splitting the joint family (bine basne; chutaune) does not occur only on the death of the father. The ideal is for the brothers to continue to live together under the leadership of the eldest. The reality is often a split even before the father's death.

9/ There is one such case in my village, but the woman's mother who is now seventy-five brought several thousand rupees with her to buy land for her son-in-law. Otherwise, she says, she would have been ashamed to come and live in her son-in-law's house and she would have become a religious mendicant (jogini) living through begging and government religious donations. This is a fate universally dreaded by all my informants and despite its religious aspect, it seems to be only the resort of the desperate. See the report by Okada and Rana, "The Child Beggars of Kathmandu" (Research-cum-Action Project, Paper No. 2, Kathmandu, 1973) for some statistical data on the numbers of such women.

10/ The good daughter-in-law is expected to rub oil on the sasu's feet and massage her legs at bed time, wash the sasu's clothes and bedding, and before each rice meal, drink the water in which the sasu's feet have been ceremonially washed as a sign of humility and respect.

11/ Young daughters-in-law are practically never given the keys to the store room while daughters of the same age and much younger will be entrusted with them.

12/ Often, in fact, men used to bring in second and third wives even after the first wife had borne a son. But such weddings, though legitimate, were done without parental consent and financial aid or broad social approval because they were obviously for the man's pleasure and not for duty.

13/ The phrase used when a girl is brought in to be second or third wife is: Sauta māti bihā garnu. Literally it means to "marry over (or on top of) a co-wife" and it belies the fact that, although the new wife should give ritual deference to the elder wife, she often has more power in the household because she usually has the husband's affections.

14/ For further discussion of this Hindu dicotomy see: a) Dumont, Louis: "World Renunciation in Indian Religion" in Contributions to Indian Sociology, No. IV. b) Campbell, J. Gabriel:

Saints and Householders: a Study of Hindu Ritual and Myth among the Kangra Rajputs, Bibliotheca Himalayica in Press.

15/ See footnote 1, page 2.

16/ The aśrama theory requires that the individual go through four life stages: celibate student, householder and finally two successively more severe stages of withdrawal from family into religious concerns. Before a high caste boy can marry or assume full caste status (karma caleko), he must go through the bartaman ceremony in which he temporarily becomes a brahmacharya or ascetic student of the first aśrama. The boy must have his head shaved, don the yellow robes of mendicancy and symbolically beg like a wandering ascetic from his relatives. Then only does his maternal uncle call him back to eventual marriage and fatherhood - the duties of the second householder stage. Some few villagers who can afford to in their old age do delegate most of the family responsibilities to their sons and turn more to religious concerns. But this is less a conscious fulfillment of the third aśrama than a general attitude that religion is the appropriate concern of the elderly. As mentioned previously, the fourth aśrama of wandering mendicancy is never sought voluntarily by villagers.

17/ Some women said that a child conceived on the fourth day will be a trouble-maker, while the child conceived on the fourteenth day will be laksin (:auspicious, bringing good luck). This would also seem to indicate a certain ambivalence about intercourse on the 4th day after menstruation.

18/ Men seem to be much less the subject of this kind of accounting. Although the idea of male infertility is not unknown, the "spiritual responsibility" for lack of children tends to rest more heavily with women. For example, when I presented to one informant a hypothetical case of one man who had married four wives and had not been able to have any children, she agreed that it was because the man was infertile, but added immediately that it was those women's unlucky karma to have married such a man.

19/ For fuller description & discussion, see my "Maiti-ghar: An Examination of the Dual Role of Women in Northern Hindu Kinship From the Perspective of the Chetris and Brahmins of Nepal" in The Interface of the Himalayas, James Fisher, ed., The Hague: Mouton, in press.

20/ For another description of Tij and Rishi Panchami see K.B. Bista's article, "Tij ou la Fete du Femmes", p.7 in Objets et Mondes, Vol 9, 1969.

21/ In the more remote hill areas, all ritual bathing, including the purification of the genitals, is done by the river in large groups.

22/ Yalman, op.cit. p. 32.

23/ It is said that the face of the first person a woman sees after completing her fourth day bath determines what a child conceived on that day will look like. One exceptionally light-skinned, brown-haired child in the village is said to have been conceived after his rather dark-skinned mother had seen a foreign "hippie" after bathing.

24/ Carstairs, M.G., The Twice Born. London: Indian University Press, 1967.

25/ The responsibility is a vague one being the result of some forgotten sin in past lives as the earlier informant explained (p.14).

26/ Many women showed great interest in depo pavera birth control injections when told that it would stop their periods. But they were also worried that the "old, spoilt blood" would collect and cause illness.

27/ Ghee, honey, black mustard seeds, yogurt, an herb called aledo, and the juice from inside a cactus stem.

28/ Sex is also believed to harm children if they are sleeping nearby when their parents have intercourse. Women said that an illness called moc ko betha caused by the hawa (:wind or breeze) created during intercourse affects children if they are near the couple.

29/ I found that while women perceived men as wanting and enjoying sex and themselves as weakened by it, men said the exact opposite. Though the sample of men I could discuss the subject with was, admittedly, very small; they responded that intercourse was good for women and debilitating for men!

30/ Women seemed to feel it was legitimate, however, for their husbands to sleep with their co-wives when they themselves were having their periods.

31/ I have pursued this subject more thoroughly in my dissertation.

32/ I am grateful to Linda Stone for drawing my attention to the last three classifications.

33/ Infertility and miscarriage are, of course, only two of the many illnesses and misfortunes ascribed to witchcraft, and males and children are just as vulnerable as women though perhaps less frequent victims. The cause of almost any illness or at least its failure to be cured, can be ascribed to witchcraft.

For fuller discussion of witchcraft in the village setting see Linda Stone's article "Concepts of Illness and Curing in a Central Nepal Village."

34/ There are some methods of counter-acting the bokshi's work which even non-specialist can do. See page 44. below for a description of some common protective practices.

35/ Tunu is the verb "to miscarry" and is used commonly for animals and for humans - but for humans tueko or tuera palyo implies more responsibility for the miscarriage.

36/ This is consistent with the strict shielding of a woman's sexuality (starting with the gupha basne puberty rite) from her male consanguineal kin. For fuller discussions see my article "Maiti ghar" op.cit.

37/ Others including older Brahman men may also be called in to judge the length of labor.

38/ This practice may be partially responsible for the high incidence of procidentia uteri (prolapsed uterus) among village women in Nepal. Dr. Prasana Gautam, personal communication.

39/ My village survey showed that of the 53 child (under 15) deaths, naite pakeko or infected navel accounted for two of the remembered causes.

40/ The nuharan name is usually kept relatively secret and used only for religious purposes like marriage. A bolaune naum or calling name is given by the family when the child is a little older and has some personality.

41/ Batisa ko dhulo (:a mixture of thirty-two ingredients bought ready made); juwano (:ligusticum ajowan); methi (:fenugreek); sop or suf (aniseed); caku (molasses); misri (:crystalized sugar); nariyol or naravan gol (:coconut); cokhra (:dried dates); kaju (:cashew nuts); luang (:cloves); alaichi (:black cardamun); sukumil (:small green cardomum); dal cini (:cinnamon); pesta (:almonds).

42/ Campbell, J. Gabriel, op. cit.

43/ The only case I have encountered of concern over slow development on the part of parents was with a six year old girl who - mostly out of shyness - hardly spoke at all. A specialist was consulted and his rather traumatic treatment was to lock the child in a room alone and not let her out until she spoke!

44/ In such cases, the child will grow up calling its grandfather ba (:father) and its biological father thulo dai (big elder brother) until it is five or six years old.

45/ This seems to be one of the first games adults play with infants. The adult asks the child for some object saying "Give" and holds his hands out for it. The child is praised when he relinquishes the object and saying "Take", the adult returns the object to the child and the exchange is begun again.

46/ Hence young husbands in a joint family sneak sweets to their wives and the theme of many festivals centers on the feeding of various kinship categories. For example, wives are fed by husbands on Tij; fathers by children on Kusi Ausi; Mothers by children on Matha Tirtha; brothers by sisters on Tihar; the ancestors by their progeny on Sraddha; and by extension, the gods are fed by their devotees whenever they are worshipped.

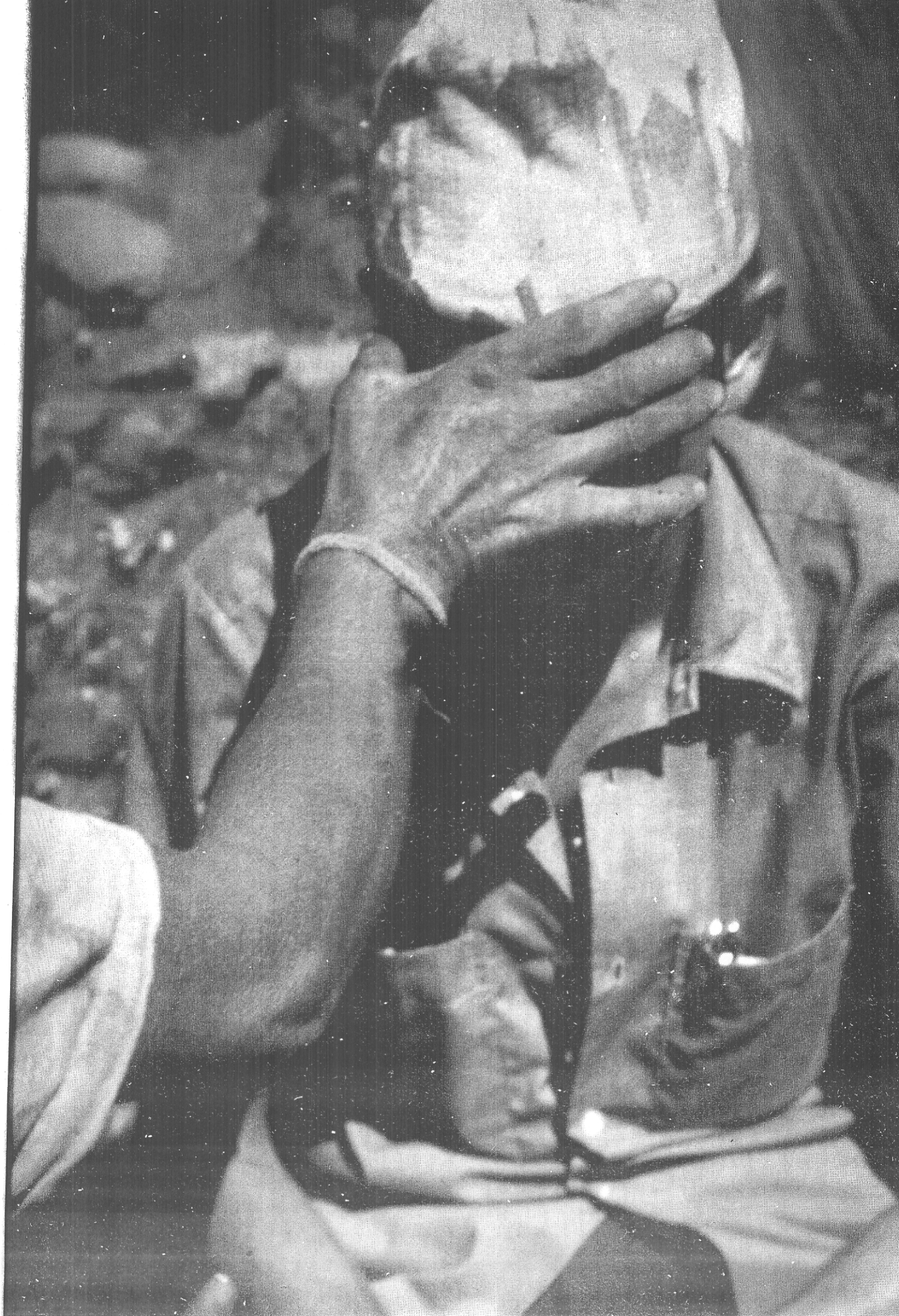
47/ Shu shu garnu: urinate; achi garnu: defecate.

48/ "Natural" and "supernatural" as used here correspond with the categories "physical" and "metaphysical" used by Linda Stone in her "Concepts of Illness and Curing in a Central Nepal Village" see elsewhere in this volume - ed.

49/ i.e. bhuts pichas et the "ghosts" of individuals who either died a violent death when it was not their "time" or whose funeral observances were not carried out properly. Pichas come back and draw attention to their needs by attacking the living.

50/ Out of 120 children borne to the 48 married women in the survey, 53 died before age 15. The greatest single category were the 15 infants who were either stillborn or who had died so soon after birth that the cause of death could not be determined or was not clearly remembered.

Treatment of a headache by application of a mantra while healer's hand grasps temple of patient. (Photo by the author)





concepts of illness and curing in a central nepal village

Linda Stone

INTRODUCTION

The research on which this description of illness and its treatments is based was carried out in the village of Dhungagaun.¹ Dhungagaun is located roughly 50 miles north-west of Kathmandu, in Nuwakot District, Bagmati Zone. The village spans roughly 1000 feet, from an elevation of 2000 feet at the lowest settlements along the Trisuli River, up to 3000 feet.

Dhungagaun is predominantly a Brahman-Chettri village; and over half of its 2000 inhabitants are of the high (sacred thread-wearing) castes. Aside from Brahmans and Chetris, other high castes are represented (Jaisi and Thakuri), as well as middle-ranking Matwali groups (Newar, Gurung, Magar, Tamang) and Untouchable castes (Damai and Kami).

Today, all of these groups in Dhungagaun interact within a common Hindu, Nepali-speaking, caste society. Yet the Matwali groups have varied somewhat in their adaptations to the dominant Brahman-Chettri culture of this region. The Gurungs and Magars of Dhungagaun have lost their traditional language and culture and are served by Brahman priests (pandits and purohits). Likewise the hill Newars of Dhungagaun do not speak Newari, though they have retained aspects of their Newar traditions. In the loss of their language and their practice of farming, the hill Newars mark a contrast with the more numerous Newari-speaking shopkeepers of the nearby bazaar town of Trisuli. Of all the Matwali groups, the Tamangs have undergone the least acculturation. Though many speak Nepali to outsiders, Tamang is spoken among themselves. They also do not employ Brahman priests. Though only two Tamang families live within Dhungagaun at present, several Tamang settlements are found at elevations above Dhungagaun.

Along with caste, kinship organization is fundamental to social and economic life in the village. Villagers are divided into patrilineal clans (thars). The unity of the patriline is ritually expressed in the common worship of clan dieties, or kuldevta. Those kin who come together for kuldevta worship are explicitly recognizing their common thar identity; and it is this group that is referred to as euta kul (one kul or one whole). Thars are grouped into larger patrilineal units called gotras. The thars and gotras are significant both in defining membership in kin groups and in the operation of marriage rules. Thars and, for the high castes, gotras are exogamous units.

Headache treated by jharnu using broom. (Photo by the author)

Within this patrilineal organization, villagers live in virilocal, joint-family households, with the eldest functioning male member as household head. The household unit is particularly important because it is a primary economic unit. Its members are a corporate group. The basis of this economic unit is land; and the village economy is overridingly one of subsistence, wet-rice agriculture.

As with most of Nepal, traditional life in Dhungagaun is being effected by the country's development efforts. Of major importance, this rural area is the site of the Indian Cooperation Mission's Hydroelectric Project, which began its operations in the early 1960's. As a result of the Project, the village was linked to Kathmandu by road; and Project jobs were made available to several villagers, providing one alternative to full-time farming. This area has also been effected by educational development, agricultural programs and family planning projects.

Of greatest importance to this study of traditional treatments of illness is the opening of Dhungagaun to medical development. Aside from the government health centers in Nuwakot District, villagers have access to a small hospital in Trisuli, built by the Indian Cooperation Mission. Today, villagers are clearly aware that new alternatives to their traditional treatments exist. And much of the complex interaction between the traditional and the modern in Dhungagaun can be seen within the realm of illness and its treatments.

This report begins with a discussion of local conceptions of illness causation and the principles behind curing. The use of herbs, mantras and amulets is covered, as well as techniques for appeasement of supernatural forces. Another section deals with the local medical specialists in Dhungagaun and observed patterns in the consultation of a specialist. A discussion of the cultural and psychological aspects of illness is also offered. Finally, I have attempted a brief analysis of the interaction between traditional curing practices and modern medical alternatives.

Medical development in rural Nepal presents a great challenge to the Nepalese Government and other development agencies. It is my belief that an understanding of traditional practices regarding illness will facilitate the attempt to introduce new conception of illness and its treatment in Dhungagaun will be of use to those engaged in Nepal's medical development efforts.

A. Principles behind the process of becoming ill

Central to local conceptions about illness is the notion of the body having multiple links with the metaphysical universe, any one of which may be related to illness. One link is maintained between a person and the planets, as determined by astrological calculations. A misalignment between one's self and the planets

spells misfortune. A person in this condition is said to be in a state of graha bigrayo (his astrological position has gone wrong; sometimes also expressed as "the planet gods have become angry before him"). Many types of misfortune, including illnesses, may be attributed to graha bigrayo. If an individual's physical, mental, or social adaptations are severely affected by the planets, the condition is called khadko (lit. crisis). Khadko, when it refers to physical or mental illness, applies to conditions with vague, otherwise unaccountable symptoms that persist over a long period, or to the physical effects of extreme ill-luck. Instances of a gradual loss of weight, a darkening of the skin, apathy, neurotic disorders or behavioral problems may (depending on the specialist consulted) be labeled khadko. In Dhungagaun, I have heard this condition applied to a young boy who suffered thinness and disinclination to attend school; to an adolescent who repeatedly disobeyed his parents; and to a man who suffered injuries from an ill-fated fall.

Another significant link maintains between a person and host of "evil spirits" collectively called lagu. The lagu category covers species as bhut, pret, masan, pichas, bir (spirits formed from souls of people who have died in an "improper" way,² or for whom death ceremonies are not performed), bokshi (human witch), devis (manifestations of the goddess Kali), nags (water spirits), and Bhume (earth god).³ The lagu category applies to any harmful spiritual force about which one can express the attack made with the verb lagnu (to strike/to attack). Thus, one expresses a state of illness from these forces as bhut lagyo, naga lagyo, etc. The lagu are opposed to another order of spiritual beings which includes Hindu gods worshipped in temples, the kuldevta (clan gods), graha (planet gods), and the bayu (an ancestor spirit). These spiritual forces do not attack individuals or directly inflict harm. They can, however, become angry (if, for instance, they are neglected in worship). In this case one does not express his relation to these spirits with the verb lagnu, but with the verb bigranu (to go wrong)--e.g., graha bigrayo, bayu bigrayo. The displeasure of any of these spiritual forces places one in a state of sin and moral danger, but only the case of graha bigrayo is, as discussed, related to specific events of illness in individuals. The lagu, on the other hand, simply attack innocent people from their own malicious needs. Here, the individual is morally neutral, but his physical or mental state is endangered.

Villagers radically disagree on just what many of the lagu are. This disagreement is particularly evident in the first class of lagu--the souls of people who have died improperly. Some informants suggest, for instance, that a pichas is the spirit of a dead person for whom death ceremonies are not performed. Others say a pichas is the spirit of a "small caste" person who dies by accident. No one is able to specify how a bhut differs from a bir or pichas in essence. Asking what each of these spirits are

will inevitably invoke references to people, or particular classes of people, dying in an improper way; but there is virtually no agreement on how the particular spirits are, by such processes, brought into being.

Each of these spirits is, however, associated with particular attributes, about which there is general agreement. Bhuts wander about, unseeable, attacking their victims at crossroads at night. Masans dwell about the ghat (burning place of the dead) and, hence, riversides. Although most people maintain they are unseeable, one Tamang jhankri claimed he had seen them and could show them to anyone who cared to accompany him to the ghat at midnight. He described those he had seen in ghoulish terms--some with no heads, some with body parts in the wrong places, etc. Of pichas (and also of bhuts) people say they are attracted to dirty places--houses where people are ill, places where people defecate, and so on. The pichas in particular is attracted to illness and is able to make wounds worse or further weaken those already in an ill state. Birs have few characteristics as a group. Most local specialists in the treatment of illness maintain there are 52 types of bir; but I did not find a practitioner who could list more than a few. Some birs are said to resemble pigs; others, buffaloes; and others, men. Many are associated with colors. The names of a few are kalo bir (a black bir), dwanse (blackish-brown), singlare (black and white and "like a man"), and dare-masan bir ("a bir with a long tooth").

Despite their descriptive differences, all of these spirits share in common the ability to harm people or their livestock through causing illness or death. Further, all attack from hunger; and their attack is designed to elicit food offerings from their victims. Sometimes these offerings are considered as a substitute for the victim's own body which the spirit desires to eat. Finally, all of these spirits attack of their own volition or at the direction of a bokshi.

The types of lagu thus far discussed are considered asexual. Only the devis (female) and the god Bhume (male) are given a sexual distinction. Although priests will explain that devis are manifestations of the Hindu goddess Kali, most villagers consider them merely as distinct and unrelated goddesses. Unlike the other lagu, various devis are worshipped regularly, or during specific festivals. But in times of devi lagyo illness, special offerings must be made to the particular devi responsible. The most common illness-inflicting devis are those which attack children--e.g., Akash Devi (Devi of the sky) whose shadow may fall upon children and harm them; and Simbu (also called "Nepale" on account of her origin in the Kathmandu Valley). Aside from attacking of their own accord, most villagers maintain that devis can be sent by bokshis.

Bhume, the earth god, is also regularly worshipped; and, in Dhungagaun, his shrine is next to that of Devi. Attacks by Bhume, as well as attacks by the nags, are rare. Unlike the other lagu,

Bhume and the nags attack from anger (over human disturbance of water or earth) rather than hunger. Further, they attack only of their own accord and are not sent by bokshis.

In certain respects villagers conceive of their spiritual world along the model of caste. As mentioned, villagers are unable to distinguish (in essence or origin) the "dead soul" lagu division. In explaining this problem, several informants draw a direct comparison between the human castes and these lagu divisions: Brahmins, Chetris, and so on, are all people but have different names and habits; in the same way, bhut, pret, etc., are all lagu with different names and characteristics. Further, the lagu and other spirits are ranked. Informants agree that there is a major division between the lagu and all other spirits, the later being "higher". Among the lagu, the "dead soul" divisions and bokshis are lowest of all; devis, Bhume and the nags are higher. Among non-lagu spirits discussed here, the bayu is lower than the kuldevta.

Of all the lagu, the pichas assumes particular importance because of its relation to the bayu. A person who dies in an "improper way" may become a pichas. This spirit may, then, harm human beings at random or it may inflict harm on its own living kul members in an effort to become a bayu of that kul. If the kul members then worship their ancestor-pichas, this pichas is transformed into a bayu and passes out of the lagu category. Although villagers cannot well distinguish a pichas from a bhut or masan, it is universally agreed that only a pichas can become a bayu. In general, a pichas wishing to become a bayu will confine its illness infliction to the babies and livestock among its living kul members rather than harm the adult kul members themselves. Once a pichas is transformed into a bayu (and, by implication, receives regular worship) it ceases its harm.

The unit which carries out bayu worship is identical to the unit which worships kuldevta in common; and nearly every kul in Dhungagaun has one or more bayus.

Only a local practitioner, called in Dhungagaun a janne manche (one who knows), is able to determine whether illness in one's children and/or livestock is due to an ancestor-pichas wishing to become a bayu. If the family accepts this diagnosis, they must summon a janne manche for the ritual transformation of their ancestor-pichas. The male kul members gather together and the janne manche invokes their bayu into his body. The pichas speaks through the possessed man to make its wishes known. The janne manche then asks the pichas to enter whatever kul member it seeks as its most promising vehicle for future invocations and worship. One kul member then becomes possessed. A fire will have been built and if this kul member, in possession, enters the fire briefly, the

act stands as proof that the pichas (and not some other interfering spirit) has possessed him. The chosen kul member must hire the janne manche to teach him the secret mantras (formulas of words) needed to invoke the bayu on his own. This person then becomes the bayu-invoker for the regular worship of the bayu by its kul; and he must later transmit this knowledge to his own patrilineal descendents before his death.

The creation of a bayu not only cures the ill and prevents further trouble to a kul, but the bayu can also be invoked at any time by a kul unit for advice on their subsequent illness cases. The bayu is said to "know things" and is able to specify how a person became ill and what he must do to recover.

Although bokshis are considered in the lagu category, they are a particularly distinctive form of lagu such that witchcraft constitutes a special and third, link between the body and the metaphysical universe. Two distinct ideas on witchcraft are locally expressed: 1) that witches are evil people who deliberately learn their magic in order to harm others; and 2) that there is "a little bokshi in everyone", an unconscious phenomenon that normally lies dormant, but can be activated in times of anger or jealousy. Most janne manches maintain that both of these conceptions are true: everyone, unconsciously, is a potential witch, but particular individuals deliberately practice witchcraft on their enemies. Most villagers confine their interest to the first conception and many are unaware of the second.⁴

In the first case--deliberate witchcraft--the power to harm lies not in the individual witches but in the mantras that anyone can master to use against another. In the second case, it is said that some people "have the evil power in their eye", such that the person transmits harm to another by looking at him, his food, etc. Some people have this power in the hand, with harm transmitted through touching.

In either case, villagers overwhelmingly agree that the motivation behind witchcraft is jealousy (of another's possessions, marriage alliances, education or general prosperity) or anger (as when a person fails to cooperate with the bokshi's interests). One informant gave the following illustration of witchcraft through jealous (unconscious type):

Suppose I have bokshi in the hand and I see your pretty bangles and I touch your arm like this (touching me) and say, "Oh what pretty bangles, where did you get them?" In this case I harm you through the arm by touching.

Another informant provided an illustration of witchcraft from the anger motive (deliberate type):

Suppose a man, Ram, owns a very good buffalo that gives a lot of milk. A woman (bokshi) comes to see if she can buy the buffalo. Ram offers a price but it is very high. The woman tries to make him lower it, but he refuses. Then a few days later the buffalo becomes very ill. This is bokshi work. The woman has made the buffalo ill.

One of the allegedly most common techniques of witchcraft involves the transmission of harm to a person (or animal) through his food. A bokshi may deliberately transmit this harm by ritually "blowing" (phuk garne) a mantra onto the food that the victim will eat. In discussions of witchcraft, villagers express that for this reason it is dangerous to eat outside one's own home. Further, should one fall ill after a communal wedding feast, witchcraft is inevitably suspected. Another common technique (restricted to deliberate witchcraft) involves the bokshi's use of other lagu beings. Bokshis, it is said, worship the evil-doing lagu and are able to send them to harm their victims. According to one informant, the relationship between bokshis and the other lagu is like that between Ram and Hanuman of the Ramayana: as Hanuman was the helper and servant to Ram in his epic exploits, so the lagu are the agents of the bokshis. When one is attacked by a bokshi-sent lagu, however, the counter magic involves appeasement of the lagu through ritual feeding rather than any action directed toward the bokshi.

Villagers maintain that although bokshis can be either men or women, they are usually women. All of the bokshi accusations I have heard in Dhungagaun have been against women. However, male janne manches are generally suspected of knowing both good and evil mantras and harming those who displease them.

A final, a overriding, link between man and the metaphysical universe which pertains to illness is the concept of fate (karma). Often the notion of karma is invoked as an ultimate explanation for one's illness. For instance, if a person is repeatedly ill through witchcraft, he may claim that his "bad karma". accounts for his being so susceptible to bokshi jealousy and anger.

In this light it is interesting to note that one's illness is frequently discussed within a larger story of "bad luck", rather than as a singular incident. When asked about his health, a person may not simply mention, for example, stomach troubles, but may recite a story of property loss and death in the family over a 5 - year period within which his stomach troubles emerge as only the latest misfortune.

A strong notion of fate, or karma, might seemingly suggest a lack of interest in illness prevention or treatments. Yet this is clearly not the case. Local "common sense" rules for illness avoidance (e.g., one is not to eat sugar or fish in times of a cold; one must sleep covered at night to avoid swelling, etc.) are observed; and for most illnesses, treatments abound. Rather, a link between the notion of fate and inactivity in times of illness seems to clearly arise only at the point where death becomes a real possibility. As death approaches, people explicitly express that the ill person's "day may have come" and that whether or not the person lives is completely out of anyone's hands. Although illness can be cured, one's time of death cannot be altered. A common saying in the village expresses this conception of death and fate:

हुने कुरा टर्ने काल नआई मर्ने

"Things which will be, are inevitable; until one's deathtime comes, one cannot die" (my translation).

Aside from these links between the body and the metaphysical universe, there are innumerable ways in which villagers perceive that a person becomes ill through his connections to the physical world. These types of illness are called angsarwi and are opposed to illnesses connected with the supernatural. The major categories of angsarwi illness--namely those involving air and food--will be noted briefly.

The main principle behind air/food-borne ailments is a double opposition between hot and cold on the one hand, and inside/outside on the other. Air may be either hot (garmi) or cold (chiso) and effects the body from the outside. Several foods are either hot (gharam) or cold (sardhi) and effect the body from the inside. Exposure to the hot air may result in any generalized discomfort or fatigue and is particularly related to headache pain. "Cold" air--by which is usually meant moving air, or wind, of any temperature--is related to swelling. It is believed that moving air enters the body through the pores of exposed skin, causing a general body swelling or, if entering the stomach, bloating. This concept is often invoked by villagers as an explanation for why they remain fully clothed in hot weather, at night while sleeping, etc. Women who have just given birth are considered particularly vulnerable to the swelling effects of "cold" (moving) air and are for this reason kept fully clothed and in a draft-free, fire-heated room even in the hottest months when temperatures soar (see Bennett-Campbell, 1974: 37).

Food is related to a variety of stomach troubles. Food that has "gone bad" (kharab) or has been tampered with by a witch is considered an obvious source of stomach pain. The hot-cold distinction is also readily referred to for stomach discomforts. Locally, particular foods are placed in an innately "hot" or innately "cold" category. Examples of "hot" foods are meat, eggs, milk, and tea; of

"cold" foods, yoghurt, mohi (a mixture of yoghurt and water), cucumbers and bananas. Several foods, particularly staples such as cooked rice and other grains, are not categorized as either hot or cold. On the other hand, all cooked food that is eaten while very hot is considered to be transformed into the "hot" category, even if such a food is in its natural state a "cold" food (e.g., lentils). Ideally, one maintains a balance of hot/cold in their food intake. If one consumes foods of either category in excess, illness results, expressed as either a feeling of hotness (gharam) or coldness (sardhi). Although there are many herbal and other remedies for these conditions, the most common cure for hotness or coldness is consumption of foods in the opposite category.

Aside from suffering sardhi or gharam, one can be affected by a more severe breaking down of the sardhi-gharam balance, a condition called sardhi-gharam bigrayo (a breaking down of hot/cold; also called dagdhi bigrayo). Interestingly, this condition is not only caused by unbalanced consumption of hot or cold foods but also by "cold" air entering the body through the pores. It is believed that air can so affect a person when they are already in a state of weakness. In this condition, one feels hot inside and cold outside. Generally the condition is also accompanied by swelling or puffiness. Sardhi-gharam bigrayo may also be caused by eating hot food in cold air or cold food in the hot air. A common remedy for sardhi-gharam bigrayo again reflects a mixing of the hot-cold balance. A host of spices--some in the hot category and some in the cold category--are ground up together. Half of this mixture is fried. The process of frying transforms those spices in the cold category into the hot category. The fried half is, then, all "hot". This portion is then mixed with the unfried half (which is half "hot", half "cold"). The resulting substance is reground and eaten, a portion at a time for several days. The treatment is said to effect an internal cooling and an external warming.

Within this context of physical-and metaphysical-related illness, there are additional notions about the process of becoming ill that are reflected in the words and expressions villagers use to discuss their ailments. The language of illness in Dhungagaun presents an image of man as being helplessly preyed upon by larger illness forces. This notion can be seen by contrasting the illness imagery of the Nepali spoken in Dhungagaun with that of English. English speakers often employ a military imagery to designate illness processes--e.g., in references to germs invading or attacking the body. Although this military imagery suggests that an individual is somewhat victimized by illness, it also implies that he can, as it were, survive by counter-attack--e.g., references to "fighting off a cold" in particular, or "combating diseases" in general. In English, illness is a war in which we participate.

In Dhungagaun, the idea of victimization by illness is expressed, but the counteridea of one's potential control over his illness is not. Here, the notion of man being helplessly preyed upon is

expressed with the imagery of food and eating: diseases and ailments become like personified forces that feed upon man. For example, one word for heart trouble, heart attack, or chest pain is mutukhane: "heart eating". Similarly, a food-eating image surrounds the word dhamki (asthma). One would not likely use the term dhamki in talking to a dhamki sufferer himself, or with reference to a close relative. This is because of the expression "dhamki ko ahara", uttered to an enemy in times of quarrel. In the context of an insult the phrase means "you are nothing but the food of the asthma disease." Parallel insult phrases can be formed from the illness words haija (cholera) bhirungi (syphilis). Finally, malignant supernatural forces, as discussed, attack from a state of hunger and inflict illness as a means of being fed by their victims. There is also the notion that some of these spirits are attempting to eat the body of victim.

B. Principles behind curing

1. Foods and herbs

A great variety of herbal and food mixtures are commonly prepared and used for nearly any illness. Many such remedies are known by all villagers, though several are taken only on the instruction of local practitioners. A great number of herbs are available locally from plants growing around every house. Some are available in the village forest areas and are considered more difficult to obtain. Still other herbs and medicinal substances (and generally those which are considered most potent) are found only in the high lekh (mountain) areas. These are collected by Tamangs who live at such altitudes and are sold to individual villagers, local practitioners and baidhyas (see section C. 3 below) in the bazaar areas. Of these medicines, the most potent and frequently sought are kasturi (from the musk deer and thulo aushaudi (lit. "big medicine"), a root of a particular lekh plant).

There are two important concepts involved in the relation between food preparations and illness: 1) the use of special food for the maintenance of an internal hot/cold balance (as discussed) and 2) the idea of tagatilo or "nutritious" foods helping one develop a state of good health or to recover from conditions involving thinness or weakness. Tagatilo foods are said to give one strength. Meat, eggs, and foods rich in ghee are tagatilo. Generally these foods are considered "heavy" and more difficult to digest, as opposed to "light" foods such as fried corn, skinned peanuts and yoghurt. Any vitamin tablets, available from the hospital or in the bazaar, are considered tagatiolo (and called tagatilo aushaudi, "nutritious medicine").

2. Appeasement of harmful supernatural forces

If a person believes he has been attacked by a lagu (a diagnosis that only a janne manche or astrologer can give) the cure

will involve an appeasement, through ritual feeding, of the particular malignant spirit. In some cases, a lagu is first appeased with a promise of a later feeding ceremony. Such action is generally taken if the arrangements for such a ceremony cannot be made immediately. It is believed that once a promise is made, the lagu involved will decrease its harmful effects in face of the mere suggestion of an imminent feeding ceremony. A promise to a lagu is made by placing some acheta (consecrated rice) in a cloth and putting it between the beams of the ceiling inside one's house. While placing the acheta, one verbally informs the lagu that this act shall serve as a guarantee for a later feeding ceremony. Often a janne manche summoned to treat a patient will himself make the ritual promise to the lagu inside the patient's house. In this case, he may also put a mantra into the acheta. His act is called acheta utaune (raising the acheta). If the patient (or a family member) makes the promise it is called bhakal and no mantra is used.

Ritual appeasement of devis, nags and Bhume are relatively simple. Generally a janne manche diagnoses these spirits as responsible for an illness, but the patient himself carries out the ritual act of appeasement. An appeasement of these spirits is termed puja and involves the preparation and offering of foods to the spirits. The devis, however, are distinctive in that they generally require a blood sacrifice.

The forms of appeasement for other lagu cover a great variety of complex ritual activity. Here, only two common types of illness ritual will be described: 1) the ritual feeding of lagu through setting out of a food plate and 2) the blood sacrifice to a bir.

a) The lagu food plate

Lagu-feeding is termed manchanu if done for a bhut, masan, or bir; and parсанu if done for a pichas (i.e. a non-kul pichas that attacks any individual) or pret. Lagu-feeding may be done either by a janne manche or by the male relation of the ill person. Often women prepare the food plate; but women do not participate in any other part of the ritual.⁵

A food plate is made from leaves of the sal tree. Uncooked rice and other grains are placed inside the plate as food offerings. Strips of cloth (cloth offerings) are placed over the food. Finally, a murti (statue)⁶ is made to represent "a person" and is placed in the center of the plate. The murti is often made out of mud and resembles a human figure, with corn silk stuck into the head as hair. Most informants did not know why a murti is put in a lagu plate. A few suggested it was merely put there so that the lagu would recognize the plate as a human offering. Wicks must also be placed in the plate (:to be lit, so that the lagu will find the plate in the dark"). For this, smaller leaf plates are made and attached in a

circle to the rim of the larger plate. One wick is put in each smaller plate. The wicks are often colored, either red (abir), yellow (besar) or black (from ash).

Blood (of a chicken, pigeon or goat) may be added to the plate although this practice is rare. Generally, the addition of a blood offering is made in accordance with the instructions of a janne manche conducting the ceremony. Birs, however, are felt to have a strong desire for blood; and if a bir is appeased with a food-plate ritual, blood is inevitably added to the food offerings.

After the plate is prepared, a janne manche or male relation of the ill person sprinkles water over the ill person and circles the plate about his head. As he circles the plate, this person chants commands to the lagu. The chant does not follow a set formula, but is merely a formal explanation to the lagu (in whatever words the speaker chooses, but with rhythmic voice) that he is being fed and must, therefore, cease his harm. Next the patient is instructed to pull out a bit of his hair and a piece of his fingernail, which are then tossed into the plate. In contrast to their explanations for the murti, informants clearly indicated that a victim's hair and fingernail are given to the lagu as a symbolic substitute for the victim's own body which the lagu wishes to eat.

Lagu plates are set out on paths or cleared areas away from houses at night. The exact location and ritual manner of placing the plate for the lagu may vary according to which lagu is involved and any particular instructions from a janne manche.

b) Blood sacrifice to a bir

A bir is considered the most dangerous of the lagu and is generally appeased with blood. Although birs may be dealt with by manchanu, more severe cases of bir attack often require a more complicated ritual sacrifice. For these ceremonies, a janne manche is generally required.

The bir is also distinctive for its manner of attack: other lagu approach people at, say, crossroads, mysteriously inflict their harm, and depart. Birs, on the other hand, may enter their victims⁷. A person so attacked is likely to fall into possession (kameko), during which he trembles and speaks the words of the bir. Birs control the victim's mind and use his speaking apparatus. When in a state of bir possession, a person is said to be unaware of what he is doing and saying. When not trembling, the victim is ill with any variety of symptoms--coughing, weakness, body pains, fever etc. A person attacked by a bir may spontaneously tremble, or a janne manche may be needed to call forth the bir and thus induce possession in the patient.

However the bir makes his presence known, another person (often a janne manche) carries on a conversation with it while the patient trembles. The pattern of these conversations is simple and recurrent: the bir is asked what it wants; the bir wants food offerings, especially a blood sacrifice; the family of the patient promises delivery if the bir will cease its harm. Bargaining takes place between the parties over what will be offered, how soon and whether a janne manche is needed to perform the ceremony. When an agreement has been made, the bir departs and the trembling of the patient stops. Often another person must shake the victim and call his name before the victim ceases trembling.

Although birs may, as recorded, attack of their own volition, serious illnesses diagnosed as bir attack are often accompanied by speculation and gossip on the possibility of witchcraft. Sometimes the janne manche consulted will specify whether a witch is behind the trouble.

A janne manche's ceremony for a blood sacrifice to a bir only takes place at night. It involves: 1) building a structure for the invocation of spirits, 2) invoking spirits, during which the janne manche goes into possession, 3) a conversation between the janne manche and the bir, with final bargaining and agreement, and 4) a ritual blood sacrifice to the bir.

Ceremonies of this type (as well as other special curing ceremonies performed by janne manches) involve two distinct processes, or functions. One is the cure of the patient. Another is the invocation of other spirits for information or advice sought by other assembled people. These spirits are the janne manche's own special gods (see section C. 1 below). As the janne manche invokes his spirits, assembled people ask the spirits questions about their particular troubles and the future (e.g. "How can my sick child become well?"; "Will my wife, who ran away to her maiti, return?"). This portion of the ceremony occurs first, before the patient is attended. The assembled group may merely consist of the family of the patient (if the family has been careful not to mention the performance of the ceremony to their neighbors) or it may consist of a large crowd of villagers.

The structures built for the performance of this ceremony vary in detail from janne manche to janne manche. But generally a design is drawn on the ground with rice flour, on top of which are placed food and other paraphernalia brought, upon the janne manche's instruction, from the patient's house. Common items in such an assemblage are: uncooked rice, paisa coins (later given to the janne manche), red and yellow powder, ash, oil wicks, incense, ghee, and an egg. The janne manche's own paraphernalia is also set here, which may include items as a knife, porcupine quills, and wooden images. Each portion of the assemblage seems to have one of two functions--either to attract needed spirits or to keep away unwanted spirits and other evil powers (e.g. bokshis) and so protect those

assembled. Food items perform the former function; and the janne manche's knife, quills etc. perform the latter function.

The janne manche calls forth spirits by his mantras and his tapping with a stick on a tin plate (explained as "music to summon the spirits"). The janne manche goes into possession with each spirit and the spirits speak through him. If outsiders (non-family) attend such a session, they may petition the janne manche to invoke advice-giving spirits on their behalf. Petitions are made by taking a leaf-plate full of rice and piasa, touching it to one's forehead, and placing it by the janne manche. In contrast to the ceremonies of Tamang jhankris described by Hofer (1973: 171) petitions are made in succession and the janne manche knows immediately for whom he is invoking spirits.

When these invocations are over, the patient for whom the janne manche was summoned is brought forth and seated on a mat before the janne manche. At this point, the patient and the mat on which he sits become untouchable. Following the invocation of the patient's bir and the final bargaining, a sacrifice is performed. The sacrifice may take place either amid the janne manche's paraphernalia or (especially if a large animal such as a goat is sacrificed) at a shrine built for this purpose away from the house. Generally, the janne manche uses an assistant (who may be his own pupil-apprentice) to perform the cutting while he utters mantras.

3. The mantra and jhar phuk

Another major principle behind the curing process is the use of the tantric mantra. The mantra, as mentioned, carries power within itself; its effective application requires only that one learn it properly. The application of the tantric mantra in curing follows a two-stage process: 1) the utterance of the mantra, and 2) the placing of the mantra onto the body of the patient by the technique of "blowing" (phuk garne). Blowing is generally accompanied by another process called jharnu (lit. to take out, to sweep or shake off). A janne manche takes an object (e.g. a broom), passes it slowly across the patient and then forcibly thrashes it to the ground. This action is said to take out the ill condition (the pain, the influence of spirits etc.) of the patient and to literally transfer it out of his body. When a janne manche uses mantras in the application of both the techniques of "blowing" and "taking out", the process is referred to as jhar phuk.

Mantras in jhar phuk are used for any and all illnesses and ailments, regardless of whether a condition is angsarwa or caused by a lagu. Only the mantra and the janne manche's particular paraphernalia will vary according to the nature of the condition. Generally, jhar phuk is performed as a first measure for any illness, with other curing techniques attempted if the patient does

not recover. It is also used in combination with other types of treatment--e.g., a janne manche will generally do jhar phuk on his patient both before and after performing a sacrifice to a bir.

Of greatest importance, the janne manche's mantras and technique of jhar phuk are considered the most effective counter-measure for illnesses connected with witchcraft. If a bokshi has inflicted harm with evil mantras (i.e., without sending other lagu to inflict harm), jhar phuk is essential. The janne manche is said to have "good" mantras that can directly nullify the "bad" mantras of the bokshi.

The idea of treating witchcraft-related illnesses through action directed toward the bokshi herself is only minimally expressed in the village. Most janne manches maintain that direct bokshi harm can only be treated with mantras and that if a bokshi sends another lagu to do harm, the lagu and not the bokshi must be ritually fed. Only one janne manche I interviewed claimed that it was conceivable to ritually appease (through feeding) a bokshi. On the other hand, many villagers are unaware of just what a janne manche is doing in his rituals, and several claim he is appeasing the bokshi herself (or, rather her "soul") when for the same rituals, the janne manche maintains he is appeasing a bokshi-sent lagu.

Most janne manches do claim that they have the power to nullify, sicken, or kill bokshis, through the use of mantras. Yet, I have never heard of any of these actions actually being performed. Nullification techniques are socially perilous (e.g., forcing the bokshi to eat human feces, or pulling out her hair); and most janne manches maintain they will not harm or kill a bokshi because it would be sinful.

For certain illnesses, janne manches use the mantra alone without the accompanying technique of jharne. For instance, one particular use of the mantra is for the literal removal of trouble-giving matter in the body. In such cases, it is suspected that a bokshi has inflicted the harm by placing putla inside the body of the victim. The bokshi obtains some substance from the body of the victim (such as hair or fingernail), the victim's possessions (a piece of cloth from clothing), or something that the victim has touched. The bokshi then blows an evil mantra onto this item and, through the power of the spell, the object literally enters the person's body, causing pain. A commonly observed putla extraction is the removal of dirt from a victim's body. The bokshi, it is said, picks up the dirt from the ground over which the victim has just walked. She blows a mantra into the dirt and then tosses it into the victim's body. For the removal of the dirt, the practitioner places a container of water on top of or next to the pained portion of the patient's body. He blows a mantra onto the pained part of the body and, within minutes, the putla dirt appears in the water, first clouding it, then settling at the bottom of the container.

4. Amulets

For more serious cases of lagu-caused illnesses, janne manches make amulets for their patients to protect them against future harm from all lagu. The amulets are made after other curing ceremonies are performed for the patient. The other curing ceremonies are performed for the patient. The patient is instructed to wear the amulet on his person at all times. Amulets are said to be 100% effective against all lagu, but they are only effective for a limited amount of time, as determined by the janne manche. Amulets are normally made to last anywhere from one month to a few years, but janne manches vary greatly on the length of time for which they will guarantee their amulets.

There are two types of amulets: jantra and buti. A jantra contains a mantra written on paper which is then folded up inside a piece of cloth and worn around the neck on a string. A buti contains "medicines"; and, as with the jantra, these are wrapped in cloth and worn about the neck. The medicines are generally herbal plants and animal parts (claw of leopard, skin of a jackal, etc.), both of which must be obtained from the jungle or the high lekh areas. The janne manche must obtain these substances himself or buy them from Tamang traders. As a general rule, butis are made for children and jantras for adults.

In some contexts the amulet is associated with the janne manche who made it and reflects a degree of competition between practitioners. For instance, if a janne manche is summoned to treat a person who is wearing an amulet made by another practitioner, he may order the client to throw the amulet away before he will attempt his own cures.

C. The Specialists and the Pattern of Consultation1. The janne manche

Of all the specialists employed by villagers for illnesses, the janne manches are consulted most frequently. In Dhungagaun, one can distinguish three types, or grades, of janne manche: 1) those who know mantras for a variety of illnesses and practice jhar phuk 2) Those who are additionally able to make jantras and butis, and may know a few special curing techniques, e.g. putla extraction and 3) those who are, beyond all the above, able to invoke spirits.

The janne manches in the last category each have a set of spirits which they may call. One of these is inevitably their own bayu. The others are termed "guru" and each will have a separate name as well. The janne manche acquires these spirits (or the techniques for invoking them with mantras) from another janne manche

whom he has employed as his teacher. Often a father will transmit his curing knowledge and his "guru" spirits to a son. These spirits are male and female (devi) gods. They do not include lagu spirits although a janne manche may be able to invoke these as well. Some of the guru gods of janne manche are Tamang gods--e.g. the god Changrashi. Acquiring these spirits from Tamang jhankris is a common practice.

Villagers maintain that the term jhankri should not, technically speaking, be applied to their local janne manches. A jhankri, they point out, is a Tamang practitioner "who has long hair". But in practice the term jhankri is rather loosely used; and in several contexts the janne manches are referred to as dhami (medium) jhankri or dhami-jhankri.

Janne maches of Dhungagaun undergo no initiation ceremony, nor does an individual become a janne manche through any special spiritual "calling" or original possession. The janne maches, further, wear no special costume during their ceremonies. Though they become possessed by spirits, they take no "journey" to the heavens or the underworld. In all these respects they differ from, and represent a far less elaborate complex than the Tamang jhankris of the higher settlement areas (as, for example, described by Höfer, 1973) or the shamans of other areas of Nepal (see, for example, Watters, 1975).

One becomes a janne manche simply by learning how--learning mantras, the techniques of diagnosis and spirit invocation. Although it is said that anyone, man or woman, can learn the practice, only men in Dhungagaun actually do so. The number of men in Dhungagaun who regularly apply mantras to the ill (and/or practice ankat herne and the making of amulets) is seven. Aside from these men, janne manches from other villages may be summoned to Dhungagaun only two men (one Chetri, one Brahman) are able to invoke spirits in curing.

Villagers maintain that Tamangs are particularly powerful practitioners. The Tamangs they call however, are with rare exception, not shamans such as Höfer (1973) describes. Instead they are the highly acculturated, Nepali-speaking Tamangs who live in lower areas and whose practice does not differ from that of other village janne manches. One such Tamang jhankri, who was summoned to Dhungagaun, claimed that he learned his mantras and curing techniques from a Newar Gubaju of the Kathmandu Valley.

During the process of becoming a janne manche, one commonly acts as an apprentice to an experienced practitioner for a number of months. Often a janne manche uses an apprentice as an assistant during curing. The apprentice must pay his guru for his teaching services. Commonly expressed motivations for becoming a janne manche are "to help others" or "dharma auncha" (to acquire religious

merit). Monetary rewards may also be substantial, although no janne manche relies totally on curing work for his livelihood.

Janne manches, and other native curers, use three common techniques of diagnosis: pulse-reading (nadi herne) rice-reading (ankat herne), and the invocation of spirits. In pulse-reading, the speed and direction of the pulse indicate what has afflicted the patient. Janne manches vary, however, on how they interpret these dimensions of a pulse. One janne manche claims that a rapid pulse that beats up and down (literally perpendicular to the wrist) indicates attack by a bhut; a rapid pulse back and forth (parallel to the wrist) indicates attack by a nag.

There are two different methods used in ankat herne. In one, the patient provides the janne manche with a plate of uncooked rice that he has touched; the janne manche takes a bit of rice and lets it fall onto a cleared portion of the plate. He then looks to see if the rice kernels have fallen into an odd or even number. This process is repeated several times and the sequence of numbers is remembered. It is the combination of the even/odd numbers that carries the message, the diagnosis. In the second method, the janne manche "awakens" (jagaune) the rice with a mantra. He then "remembers the gods" and mentally calls all spirits to "sit" on the plate of rice. He picks up a bit of rice and lets it fall on the plate. The rice will fall on the sitting place of a particular spirit, that spirit then being claimed as the cause of a client's illness.

In diagnosis through spirit invocation, the janne manche will generally invoke his own bayu. The bayu will then speak through the janne manche and reveal the cause of a patient's trouble.

Janne manches maintain that they employ these three techniques of diagnosis in a definite order: first they will read a client's pulse. If the results of this diagnosis prove inadequate, they will do ankat herne; and only if all else has failed will they resort to the invocation of their spirits.

Janne manche curing practices are many and varied. Those commonly observed--bhut feeding, blood sacrifice to a bir, spirit invoking, putla extracting and mantra blowing--have been briefly described. Although general patterns are evident, there is considerable variation in detail from janne manche to janne manche. There is also variation with the same janne manche on different occasions. Each janne manche appears to have his own collection of techniques, paraphernalia, and mantras, as well as his own set of spirits to invoke. Much of his work is considered secret knowledge: others should not hear his mantras or learn just what he puts inside of an amulet.

Janne manches tend to have an ambiguous social position. First, although their work is considered necessary and beneficial, it is not considered "high" or "good" in itself as, say, priest work would be considered. Further, villagers believe that those who know the "good" mantras for curing also know the bad ones (witchcraft mantras). The janne manches I have interviewed also claim they know the harm-giving mantras as well as those for curing. In discussing janne manches he has employed, one villager commented, "We must always be somewhat afraid of them because if they are displeased with us, they have the power to harm us." A common way to displease a janne manche is to fail to pay him enough for his services, or to call in another janne manche.

Janne manches will rarely state their prices, but will instruct their clients to "give what you want". For simple sessions of mantra blowing, usually no money is given at all. Also, for larger ceremonies in which the patient does not recover, no large sum of money is given. For these, however, the janne manche does receive the paisa coins used in the rituals; and for any service of ankat herne, he will take the paisa put in the plate of rice. When a janne manche makes a jantra or successfully cures a patient with, say, a sacrifice to a bir, the issue of money becomes important. Bargaining takes place between the janne manche and his client family, however much the janne manche may say "give what you want". In Dhungagaun jantras may cost 1-5 rupees and the total expenditures for a successful cure through bir sacrifice up 30 rupees. These payments in rupees are also supplemented with payments in grain and other foods.

The ambiguous social position of janne manches and the fact that many of their clients' illnesses persist uncured, results in a pattern of shifting clientele for each janne manche. A common pattern is as follows: a family member becomes ill and the family's regular janne manche is summoned. After repeated treatments the ill does not recover. Family members become disillusioned with the janne manche. They claim that either he doesn't really have the power to effect a cure or he is displeased with the family and deliberately does not cure the patient. Another janne manche is called, the patient recovers and faith in the new janne manche is firm. Later, another family member falls ill (or the previous one suffers a relapse). The second janne manche is recalled and the entire cycle may start over again.

2. Astrologers and Priests

Astrologers and priests are also frequently consulted for illness cases. In general, the astrologer is consulted for a diagnosis and the priest summoned to do a puja on the recommendation of the astrologer.

Through astrological calculations, the astrologer is able to determine whether the trouble is due to a misalignment in the

patient's planets. An astrologer may also mention lagu, witchcraft or other inauspicious events as influencing a case of illness. But the astrologer, performs no curing functions.

Although a priest does not directly diagnose an illness in a manner comparable to the astrologer or janne manche, he may, after observing a patient, recommend a particular puja to assist a patient's recovery. The puja ritual carried out by a priest for illness is called graha shanti swasti. It consists of 3 parts: rudri--offerings made to Shiva; putika--offerings made to Devi; and hom--offerings made into a fire for the 9 planets. These 3 rituals are generally done together, although they each may be done alone without the others. They may be done at any time to ensure general well being to a family, but they are arranged in particular when a household member is seriously ill. In the former case, all family members participate in the puja; in the latter, only the ill person participates.

3. Baidyas and Doctors

Finally, in cases of illness people may consult a baidya or a western trained doctor. The baidya deals in Ayurvedic medicines. There are no baidyas in Dhungagaun, but in Trisuli bazaar there is one medical store and the practice of making and dispensing these medicines has been handed down from father to son in this family over generations. Medicine in this shop comes from two main sources: 1) India (manufactured medicine), and 2) the lekh (high mountain areas). Tamangs collect the lekh medicines and sell them to the baidya.

There are, likewise, no medically trained specialists in Dhungagaun; but doctors are available in Trisuli through the hospital. The baidya shopkeeper and the doctors explicitly deny any validity to the supernatural treatments employed by local practitioners.

These specialists of illness treatment do not mark discrete categories, each with internal, discrete theories of illness. Rather, from the point of view of village conceptions, the practices of these specialists and the theories behind them are in several senses merged and overlapping.

First, one person may simultaneously be two or more different kinds of specialist. Most janne manches who invoke gods or practice jharphuk are also knowledgeable of herbal medicines and may in some cases dispense them without the use of mantras or supernatural curing techniques. Most priests, as well, are at least partially knowledgeable in astrology and may diagnose illnesses from astrological calculations. Further, a priest may simultaneously be a janne manche. One of the local practitioners in Dhungagaun, who invokes gods in curing, is also a Brahman purohit.

More important, case histories of the ill reflect that in prolonged cases of trouble, a great variety of specialists may be summoned simultaneously, followed by equally various and simultaneous treatments. In another respect, one does not generally base his choice of specialist on the metaphysical implications behind the work of such a specialist. One village woman, for instance, was suffering from a swollen, oozing sore. Some relatives urged her to see a doctor; others, to call a janne manche. The woman herself opted for the janne manche, explaining that she knew the man would only "blow" on her painlessly, whereas the doctor "might hurt" in giving an injection or tampering with the sore itself. That the work of the doctor and the janne manche are based on entirely different principles, each with conflicting implications about man and the universe, was irrelevant to her.

Some particular cures themselves reflect a mixture of natural and "magical" elements. The following, for example, is a common remedy for fever known to most villagers: dubo grass, cumin seed, the weed bhanjiraj, and 7 grains of rice are mashed up with water and eaten. Although most villagers offer no explanation for why 7 grains of rice are needed (as opposed to, say, 6 or 8), it is clear from many ritual contexts that the number 7 (along with 9 and other odd numbers) has magical significance. Villagers respond to the number and maintain that the medicine would not work if any even number of grains were used. Janne manches will say that the "7 grains of rice" is tantric kura (tantric thing) and therefore carries special power as does a tantric mantra.

In some cases, the question of which specialist is consulted is a function of the illness itself. Minor discomforts, wounds and sores are often treated with herbs; for more serious injuries, the hospital is almost always used; and fits of trembling (almost diagnostic for bir attack) will inevitably bring forth a god-invoking janne manche. Except for these specific, easily discernible cases, the larger pattern is not a matter of who one consults when, but who one consults first. As an illness persists uncured, one generally consults specialists in the following order: janne manche; astrologer and/or priest; doctor. Possible reasons behind this pattern are varied. One is availability. The services of a janne manche are easily available; somewhat more time and effort are required to organize the services of the priest and especially of the doctor. Expense may also be a factor. Fees to a janne manche are minimal (unless a complicated ceremony is required) whereas the cost of a puja may slightly strain resources.

The doctor's services (if consulted through the hospital rather than privately), however, are free, yet the doctor is often consulted only after all else has failed. Villagers express a lack of trust in the doctor's treatments; there are also problems with attitudes toward the hospital itself, which will be dealt with later. A final factor may be a natural reluctance to confront the seriousness of a case. In this respect the selection of a

specialist coordinates with a pattern in the diagnoses of the patient. Janne manches tend to originally declare a patient is, say, merely bhut lagyo and it is only later, when the patient has not recovered, that talk of witchcraft or more dangerous spirits begins. Summoning a priest or calling a doctor are further indications that an illness is potentially serious.

D. Cultural and Psychological Aspects of Illness and Curing

Villagers view knowledge of astrology, mantras, witchcraft, and other matters relating to illness and curing as highly specialized. Insofar as they consult a specialist and obey his dictates, they trust his word. But they do not, in general, know just what he does or why--the ideology, in effect, behind his practice and their own behavior that he directs. The villagers are clearly relating to the systems of curing on an emotional rather than an intellectual level. The perceptible moods of elation that follow, for instance, god-invocation curing ceremonies, are evidence of the emotional level of client participation. In several instances, the participants in these ceremonies have little idea just what spirit the ceremony is meant to appease or how the practitioner managed to effect appeasement.

It is interesting to consider to what extent the janne manche is aware of, or manipulates, the emotionally responsive and intellectually uncritical position of his clients. Most janne manches would not, of course, discuss their practice in these terms. One did, however, admit to me that there was nothing genuine in his use of the ankat herne diagnosis technique:

It is only something to show the people.
I use it as a device to give myself time
to think about the ill man; and when I
am doing the reading of the ankat, I am really
reading the man's face, for that is where
you will see why he has become ill.

A major part of the sociological aspects of illness and curing has to do with witchcraft and witchcraft accusations. As mentioned, it is commonly agreed that witches strike through jealousy or anger; and, not surprisingly, witchcraft accusations are made against those with whom one has important relationships or with whom one is in competition for resources. The two most common patterns in witchcraft accusations are: 1) against one's family head's brother's wife, and 2) against females of a family who (allegedly) wanted one's bride to be given to them in marriage.

Regarding the first case, conflicts between brothers mark one of the major social cleavages readily observable in village life. Villagers often say that brothers are "pulled apart" by their wives after marriage. However, it might be equally argued that the

conflict between brothers begin well before their respective wives exert an influence, and that it rests in their direct competition for shares in the family's resources. In this case, women, as accused witches, become a vehicle through which the brother-brother conflicts are expressed, rather than the cause of that conflict.

The second pattern may represent a conflict over marriageable girls as a resource. It may, however, merely be an expression of other conflicts between individuals and family units. For instance, the attributed witchcraft motivation of "they wanted our bride/daughter-in-law" is sometimes directed against the same people of the first pattern--i.e., the household head's brother's family.

In general, the pattern in the village is for separate family units to have a network of potentially accusable witches rather than a set of "known" witches that all villagers accuse. Just as a family will have their kul gods and their bayu, they will have their witch. Though neighbors and other relatives may be aware of a particular family's witchcraft accusation, they do not concern themselves in the matter, avoid the person accused, etc. Witchcraft accusations are a private affair, whispered about the home; and rarely is much ever made of them.

There are some exceptions to the general pattern of witchcraft described here. Accusations are occasionally made against one's neighbor (no relation) with whom one does not generally get along. Neighbors tend to keep a close watch on each other's fortunes and relations of mutual jealousy are common. I also knew of one case where a woman entirely unrelated to a troubled family was suspected of witchcraft. The woman was from another village and had eloped into Dhungagaun. The accusation was first made by an astrologer (also from another village) who was summoned for a diagnosis of an ill family member. He merely described the offending witch and the family quickly presumed her identity. This woman, then, may be approaching a village-witch category. However, as the case proceeded this accusation was quickly forgotten in favor of one against the family's regular witch.

IV. The Interaction between Traditional and Western Medicine: A Summary of Conclusions

As mentioned, the alternative of modern medical practices is being introduced in Dhungagaun along with other forms of development. I have found that in several contexts of illness treatment, villagers easily combine Western medicine with traditional practices. Such observations suggest that villagers have little difficulty integrating Western medicine with their own traditions on an ideological level. Even where these systems of medicine are explicitly recognized as incompatible, this recognition is not

necessarily reflected in behavior. For instance, villagers unquestionably maintain that "doctor medicine" is totally ineffective for cases of illness caused by witchcraft. Yet even in cases where witchcraft is strongly suspected, villagers do make use of the alternative sources of Western medicine in combination with traditional treatments. In my opinion, people are not in this process violating the general principles of their witchcraft tradition, but are merely allowing their interpretations of particular cases of illness to remain sufficiently ambiguous for multiple diagnoses to be simultaneously considered.

Traditional and Western forms of medicine are, however, more sharply distinguished in other respects; and some measure of conflict between them occurs on social and institutional levels. First, I have found that although villagers display a high regard for Western medicines (pills, ointments, injections, etc.) they are somewhat less enthusiastic about the institutions of Western medicine, such as the Trisuli hospital. My research suggests, that the hospital is used infrequently or as a last resort, not because it embodies a system of alien or threatening ideas of illness, but because it lacks institutional success or institutional integration with village life. Specifically, villagers point out that the quality of hospital services varies according to one's wealth and status, that doctors give only cursory examinations, that distributed medicines are old, and that provision for the observation of local caste restrictions is not made.

Secondly, there have been repercussions from the fact that developing agencies explicitly oppose modern and traditional medicine. Educators instruct school children to abandon their "superstitious" beliefs in illness causation. Doctors deny the validity of local practitioners and encourage patients not to summon them. Local practitioners, in turn, occasionally discourage clients from going to the hospital. With the lines drawn in this fashion, villagers are presented with a new realm of opposing symbols for incorporation into their social life. Of relevance here, villagers in particular contexts seek to be identified with the "modern" world, which, in this area, is largely defined as the world of the educated. Symbolic denials of traditional medical practices and confirmation of Western medicine is one of the ways in which such identification is effected. This public identification tends to occur in contexts other than those in which a specific case of illness is being treated; and in several instances a person's public stance on medicine does not coincide with his actual practices.

Thus, Western and traditional medicine are distinguished on an institutional plane as reflected in attitudes toward the hospital and in a certain amount of competition between doctors and local practitioners. On the other hand, actual treatments of illnesses reflect a high degree of integration of these systems. These

observed contexts of integration in the actual treatments of illness suggest to me that the disparity between Western and traditional medicine is not an ideological conflict over systems of medicine. It is, rather, a social and institutional conflict expressed through the rhetoric of medicine and the symbols of "supernatural" versus "modern" treatments of illness. The rhetoric has been provided by the explicit oppositions between traditional and modern medicine made by development personnel. As such, these repercussions from medical development that I have observed in Dhungagaun are involved with the much larger issue of "modernization" and with the effects of all the development forces that are reshaping rural Nepal.

NOTES

1. Field work in Dhungagaun (psuedonym) took place between April, 1974 and September, 1975. Research was carried out under a fellowship granted by the Social Science Research Council's Foreign Area Fellowship Program. However, the conclusions, opinions, and other statements in this publication are those of the author and not necessarily those of the Fellowship Program. I am grateful to Gabriel Campbell, Lynn Bennett, and Andrew E. Manzardo for their assistance with earlier drafts of this paper.

2. There are several types of death that are considered "improper" and result in the dead person's "soul" becoming a pichas, bhut etc. The commonly mentioned ones are death by fire, death by any "accident" e.g. falling from a tree, falling into a river; and death from dog or snake bites.

3. Among the lagu, devis, Bhume and the nags seem to me to occupy a unique position. Possibly they can occupy positions in both the lagu and the non-lagu categories, depending on context. These spirits, except when related to specific illnesses, are not feared or considered as evil. Further, they may be worshipped in contexts in which illness or harm is not an issue. One Brahman pandit maintained that "according to the Hindu dharma" these spirits should not be considered as lagu at all, but that villagers mistakenly think of them as lagu because janne manches have begun to refer to them as such when diagnosing illnesses.

4. Some villagers and local practitioners make a distinction between bokshi (deliberate witch) and dankini (unconscious witch). Others, however, maintain that these two terms are synonymous and that both may refer to either type of witch.

5. The presence of women is said to displease most lagu, and women incur danger through contact with a lagu food-plate once it has been set out. For instance, it is commonly believed that if a pregnant woman crosses over a food-plate that has been set on the ground, her unborn child will develop an illness called sukwa betha (thinness and drying up) and may die.

6. Some janne manche maintain that a murti is not necessary in lagu feeding and suggest that it is a Tamang practice which Hindu groups later adopted.

7. Whereas some villagers maintain that spirits actually enter the body (birs, the bayu etc.) others claim such spirits only "sit on the shoulders" of those in spirit possession.

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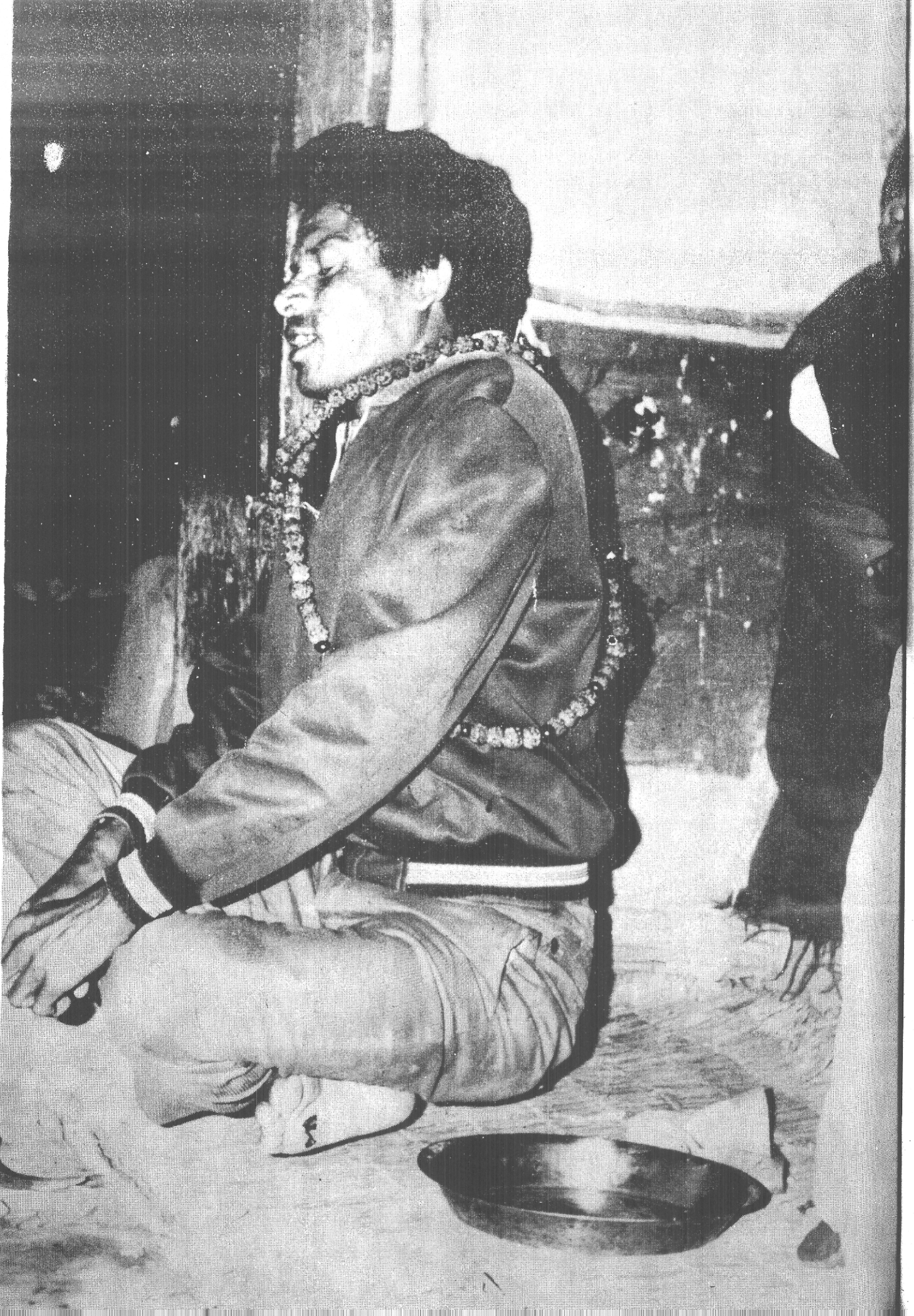
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A Damai jhankri calling the gods by banging on a plate.
(Photo by the author)





levels of medicine in a central nepali village

Harvey S. Blustain

What is medicine? For the average westerner, the word may conjure up images of stethoscopes, pills, and doctors in white jackets. The causes of illnesses are neither spirits which must be propitiated nor unknown forces acting under some cosmic whim; rather, they are impersonal agents, such as viruses or bacteria, which can be clinically tested for and treated. While there is, of course, a variety of folk remedies and philosophies designed to handle specific minor maladies, diagnosis and cure are to the layman rather mysterious processes which are best handled by those who have had the necessary training in biology, anatomy, and pharmacology. "Medicine", to the western mind, is based on the notion that science, with its methodology of research and experimentation, is potentially capable of combatting any sickness and curing any disease.

The villager in Nepal, like his western counterpart, also has ideas about what medicine should be, respect for those specialists who can diagnose and cure, and a faith in the basic validity of the system. This paper will explore methods of healing within a village of central Nepal. As will be seen, there are various techniques of curing - herbal, ritual, western - all of which are integrated into a system designed to deal with the problem of illness and pain.

Lig Lig Dumre,¹ situated in western Gorkha district, is a village of 430 people divided into five caste groupings - Chhetris (141), Damais (77), Kamis (24), Sarkis (40), and Muslims (148). The site was particularly advantageous for the study of village medicine for three reasons: 1) The economic base of the village is still agriculture. A few of the men have gone to Calcutta or Kathmandu to work, yet influences from the city remain minimal and there have been no radical changes in the traditional social order. 2) The presence of both Hindus and Muslims allowed a comparison of two systems of ritual medicine. 3) Approximately one hour's walk from Dumre is the United Mission to Nepal hospital at Ampipal. Providing a wide variety of western health care services, the hospital increases the medical options available to the villagers and adds a new dimension to the local system.

And what is that system? For the sake of clarity, several spheres will be delineated. It must be understood, however, that all of these levels are interrelated; the peasant is acquainted with each of them and some of the principles operating in one sphere are applicable to the others. Further, healers specializing in one type of curing are familiar with the techniques of the

The jhankri in a state of possession. (Photo by the author)

other village practitioners. In sum, the divisions presented here are a heuristic device; how all of the levels operate together, and how the villager decides which healer to visit, will be discussed later.

When a villager falls ill, he can consult any of a number of local healers. His first step may be to present his problem to family and friends in the hope that some simple advice and a few words of sympathy may be enough to make him feel better. Alternatively, he may head for the teashop where he may be convinced by the owner to buy a bottle of ayurvedic medicine brought up from Kathmandu. If there is a baidhya in the teashop at the time, he may have his pulse read to determine whether the illness was caused by spirits, by anxiety, or simply by too much chili pepper in last night's dinner. A Jaisi Brahman, if he is also there, may attempt to determine by his own methods whether a spirit or god is involved. And, of course, the layman drinking tea will compare the patient's symptoms to his own experiences and offer what he believes to be sound advice. Depending on the diagnosis, the patient may be instructed to boil and drink a certain leaf, worship a certain god, chew a certain root, change his dietary habits, or drink a glass of water into which a verse (mantra) has been blown. Instead of going to the teashop, however, the patient may go in search of the local ritual healer (jhankri). Again, depending on the diagnosis, the healer may say a few mantras, write out an amulet (jantar) for him to wear, tell him to come back at night when he can go into trance and consult with the gods, or recommend that he seek help elsewhere. Should the sickness be particularly acute, the patient may decide that a trip to the hospital is in order. Depending on which healer had been consulted, the cause of the illness could have been attributed to anxiety, an upset in the hot-cold balance of the body, witchcraft, intestinal parasites, or a malevolent ghost. The method of diagnosis could have involved the reading of three different arteries in the wrist, an x-ray machine, or a consultation with the spirits. Cures could have ranged from surgery to exorcism. Not only techniques, but philosophies would have varied; seeing illness as due to the conscious actions of gods (or, in the case of witchcraft, humans) is vastly different from viewing it as due to the impersonal actions of germs. In sum, the peasant experiencing illness is offered a dizzying array of divergent alternatives - from friends' advice to ayurvedic, herbal, ritual, and western medicine. Which form, or forms, of healing he chooses is for him a problem of fundamental importance.

Before discussing the various levels of medicine (aushadhi), it would be advantageous to explore some of the commonly-held beliefs about the way the system works. In all societies, everyone has some knowledge of and familiarity with medical practices. Such knowledge can range from simple home remedies to a sophisticated understanding of physiology. In central Nepal, the repositories of such information are the baidhyas.² While most of them can

exorcise spirits, their major role is in dealing with illnesses that are believed to be anatomically based. They are the ones who perform diagnoses and, through their extensive experience with plants, prescribe the cure. Because there is no clear rite of passage to being a baidhya, figuring out exactly how many there are in Dumre presents a problem; within the village, however, there are four men (three Muslims and one Damai) to whom people regularly turn for advice. The majority of baidhyas receive their training from other baidhyas. Yet there are also several books on baidhyako aushadhi printed in Kathmandu³ which provide remedies for ailments ranging from dog bites to burns to eye infections. While these books are not generally available and many of the baidhyas are illiterate, one of the village healers claimed to have gotten the bulk of his knowledge from these sources. In sum, it is the baidhyas who may be viewed as the general practitioners of village medicine.

The most fundamental of medical ideas is the division of foods and illness into hot (garmpi) and cold (sardi) categories. Health involves a balance in the body between garmpi and sardi; should an imbalance occur, illness is bound to result. Table I presents a list of those foods classified by informants as "hot" and "cold."

Table I

Garmpi - popped corn, chicken, goat, wheat, mango, chili pepper, eggs, cooked cucumber, lentils, biscuits, sugar, tea, home-made wine (raksi), milk bread (both millet and wheat), onion, clarified butter (ghiu), all spices, ginger, garlic, tumeric (besar), tobacco, mustard oil, apple.

Sardi - boiled corn, millet, pumpkin, tomatoes, pulse, candy, raw cucumber, rice beer, radish, lime, lemon, tangerine, potato, bean, gourd.

When asked to tell why a certain food was garmpi or sardi, the baidhya's standard answer was "Because it is." Nor could they explain why, for example, cooked cucumber and raw cucumber are in different categories or why millet should be sardi but millet bread should be garmpi. While there appeared to be no conscious criteria governing the classification, there was almost universal agreement among the independently-interviewed informants on which food belonged in which category. Also interesting is that fact that both rice and water are considered neutral, i.e. neither garmpi nor sardi.

Many of the maladies experienced by the villagers are also seen as either garmpi or sardi. Toothaches, which are sardi, can be kept from causing too much pain by a bottle of raksi. Headaches are of two kinds. Garmpi headaches, caused by spending too

long in the sun, are cured by resting in the shade. Aspirin should never be taken as it is itself garmi. Sardi headaches, covering all other circumstances, are cured by aspirin. The diagnosis of a particular headache as garmi or sardi is not determined by such questions as: Is it throbbing or dull? Is it on one side of the head or all over? Rather, and quite logically, it is determined by asking the patient what he had been doing when the pain started. If he had been plowing his fields, then his headache is obviously garmi.

While everyone agreed on the classification of toothaches and headaches, other illnesses presented more of a problem. One baidhya, for instance, insisted that if a person has localized body aches and a dryness of the nose and mouth, then his illness is garmi. If, on the other hand, his entire body aches, then the chances are good that it is sardi. Another baidhya maintained that such a simple method of diagnosis is inadequate and that only a proper reading of the pulse can distinguish the two (see below). A second area of disagreement concerned fevers and vomiting. All of the baidhyas stated that fevers can be either garmi or sardi. One, however, claimed that the fever is sardi if it comes only at night and that it is garmi if it comes during the day and night, or during the day only. The others disagreed and insisted that other factors, such as diet, would have to be considered. Getting a definitive classification of vomiting proved impossible. Of the three baidhyas interviewed separately, one said that again, other factors need to be evaluated; another stated that it is always caused by the body being sardi; and the third contended that it can be either garmi or sardi, but that if it was garmi, then the patient had "cholera".⁴

One way of finding out if an illness is hot or cold is, of course, to ask the patient what he had been eating. Too much chicken meat the night before, for example, might demand a diet of tomatoes. Another, more reliable means of diagnosis is through the pulse (naari hernu; lit., "looking at the wrist"). Not only can one discover if the sickness is garmi or sardi, but more importantly, one can pinpoint its exact cause. There are believed to be three major arteries in the wrist, all of which must be read. Speed and strength of the pulse are obviously important factors; yet there are also subtle differences in blood flow that escape laymen, but which baidhyas claim to pick up. For example, there are, as will be seen, 108 evil spirits which can cause the pulse to beat "fast" (chhito). Experienced baidhyas maintain that by "reading the wrist" they can distinguish which of the 108 is at the root of the illness. On a less esoteric level, there are other major readings:

- "slow" (bistarai) - illness caused by pichash, a kind of ghost commonly blamed for minor ailments

- "soft" (gilo) - caused by coughs
- "soft" (naram) - caused by too much sugar or fats in the patient's diet
- "small" (saano) - caused by spicy foods
- "very small" (ekdam saano) - caused by bitter or sour foods (amilo)
- "large" (thulo) - caused by a witch (boksi) having watched the patient eat

Of significance is the fact that while listening to the pulse, the baidhya will ask the patient about his symptoms, diet, and medical history. It's from these questions, as much as from the pulse, that the diagnosis is made. And because the baidhyas read the pulse in both arms, villagers occasionally grumble about the incomplete physical examinations at the hospital, where attention is paid to only one wrist.

Once the diagnosis is made, the baidhya will prescribe the cure. Very often this will involve "blowing" (phuknu) a mantra into food and water and feeding it to the patient (see below). Alternatively, the roots, leaves, or bark of different plants, prepared in various ways, may be recommended.⁵ Shilajit (bitumen) is considered invaluable for the cure of stomach aches. Many tea-shops also carry a small stock of ayurvedic medicines manufactured in Kathmandu; yet aside from being able to prescribe black pills for coughs and yellow ones for stomach aches, the baidhya knows as little about these medicines as the average American knows about the remedies bought in the pharmacy.

In addition to dealing with illness, the baidhyas also serve as the repositories of local medical knowledge. Which foods are good (e.g. limes because they "clean the blood"), which are bad (e.g. corn because it causes stomach upset) and which are to be periodically avoided (e.g. sugar and peanuts when you have a cough) are only a sampling of the kinds of advice offered by the baidhya. For their services, the baidhya usually receives no payment beyond a cup of tea or a cigarette supplied by a grateful patient. Only if a special herb or prolonged treatment is required does a few rupees change hands. One Muslim baidhya explained that he heals people for "good works" and that the acceptance of money would cancel out the religious merit he would otherwise receive.

The type of medicine described thus far is one with which a western doctor might feel reasonably comfortable. Granted, the specific methods of diagnosis and cure are different than those in a western hospital; yet the system is still based on the notion that health and illness are organic and physiological in nature. It is when the discussion turns to ritual medicine that a shift in paradigm is necessary. While on the conceptual level the Hindu and Muslim systems are significantly different, the Muslims have, in practice, adopted many of the Hindu beliefs and practices. What

will be presented, therefore, is the Hindu system; Muslim variations on this theme will be discussed later.

When discussing ritual medicine, the basic premise that sickness is caused by impersonal, un sentient agents must be laid aside. All of the spirits, be they witches or ghosts, choose their victims, decide the nature of the illness, and verbally argue with the healer. It is a highly personal system in which social and psychological factors play as important and as obvious a role as the medical factors.

According to the local Hindu cosmology, there are 108 gods, 108 goddesses, and 108 kinds of spirits. While all of them are theoretically capable of making a person ill, none of the goddesses, and only one of the gods (naag), were involved in any of the cases studied during the research period. It is primarily the spirits (jaasu) which figure prominently as the cause of sickness. Yet of the 108 jaasu, most of them, such as sanaichar (who harms seven-and-a-half year old children) and ulka (who controls meteors and comets), are unknown to all but a few of the villagers. In the final analysis, it is only six of the 108 jaasu - boksi, masaan, dankini, bai, pichash, and vir - which are held responsible for the great majority of illnesses.

But before giving a brief description of the various jaasu, one rather crucial point must be made. The illnesses treated by both baidhyas and western doctors cover essentially the same range - headache, fever, dysentery, etc. Yet those specializing in ritual medicine must learn to deal not only with these ailments (all of which may be caused by a jaasu), but with one other as well. Trance (kaamnu), the possession of a person by a jaasu, can manifest itself in different degrees of ecstasy, ranging from mild possession, in which, for example, only the patient's hand is trembling, to full possession, in which the jaasu speaks through the patient and "plays with the brain" (dimaag khelaanchha).⁶ The trance can be either spontaneous, in which the spirit comes of its own will, or induced by the shaman. Further, it may be the only manifestation of the illness or it may be accompanied by any number of symptoms.

The most important of the jaasu, and the most feared, is the boksi, or witch. Unlike the other spirits, which are non-corporeal, the boksi is a woman living in the village who is believed to have the power to cause illness. Their identities are generally well-known to the people of the village, although there is occasionally doubt as to the extent and frequency with which some of them practice their art. This doubt stems in part from the way "boksihood" is acquired; rather than inheriting the necessary powers, one must learn the knowledge (gyaan) through a long apprenticeship under the guidance of an experienced boksi. It is said that a boksi must teach her daughters and her sons' wives. I was told of one woman

in the village who, upon finding that her mother-in-law was a boksi, fled to her natal home for six years to escape having to learn the gyaan, returning only after her husband had moved into a house of his own. There is no inherent reason why a boksi cannot train a non-kinsman, but as one informant succinctly stated, "Would you trust an outsider with all that power?"

Sunday, Tuesday, and Thursday are the nights on which boksis hold their worship to masaan. On these occasions it is believed that the boksis don iron dresses (visible only to other boksis, thus making them appear naked to everyone else), disshevel their hair, and congregate at a prearranged spot. What occurs at this worship was a matter of sheer speculation among my informants; none of them had ever seen these meetings and they all maintained that any non-witch who did witness them would die.

One interesting point on which informants expressed disagreement concerns itself with the ability of the boksi to cause harm to a healthy person. Some villagers asserted that a witch could harm a person at any time. Others contended that she could not cause illness unless her victim already had some malady, however minor. For example, a boksi could not by herself cause a headache, but once a person had a headache, she could increase and prolong the pain. Similarly, a scratch or cut is said to occur through happenstance, but after occurring could be used by the boksi as a vehicle for inflicting greater harm.

Turner defines masaan as "burning ground where the dead are burnt; burial ground; cemetery; - ghost."⁷ Hitchcock refers to masan dokh as the "Graveyard Spirit."⁸ In their descriptions of masaan, the villagers certainly emphasized this macabre aspect. He is said, for example, to live in the river near the cremation grounds and to emerge every night to count the grains of sand along the bank. But more important, masaan is the king of all the jaasu. Thus, at the start of a healing ceremony, a shaman must always invoke the name of massan, and the successful completion of a ritual cure will often require that a chicken be sacrificed to masaan. The chicken, in fact, serves as a vehicle through which the illness can be removed from the patient's body. On the occasions I have seen a chicken used, the shaman repeatedly rubbed it along the affected part of the patient's body in the belief that the pain would be transferred to the animal.

When a boksi dies, her spirit is transformed into a dankini. Described by one informant as "the wife of masaan", the dankini is, like masaan, purely malevolent. At one healing ceremony I attended, the patient jumped up while in a trance and shouted that a dankini had entered the room. It was only after the shaman had taken the necessary steps to scare it away that the healing was able to continue.

There exist in the village cosmology two kinds of spirits that could be identified as "ghosts" - bai and pichash. If a corpse is touched by a tiger, jackal, rat, cat, cow, dog, snake, or (if the deceased was of high caste) a low caste individual, it is believed that the ghost (bai) of that person will return to harm his patrilineal kin. The bai can be either male or female; even a child can become a bai if he has died at least eleven days after birth, the traditional time at which names are given. How soon after death the bai appears varies greatly. In one case, the bai returned within a year after his death; in another, three or four generations elapsed before the ghost made its presence felt.

Regardless of when the bai emerges, its discovery and propitiation follow a fairly consistent pattern. When a person becomes sick he will attempt to determine the cause. While a shaman (jhankri) may decide that a bai is responsible for the illness, he cannot, initially at least, identify who that bai was in life. The ghost at this point is referred to as a kaacho bai (lit., "unripe bai") and is capable of inflicting its greatest harm. After an undetermined period, the patient, or a member of the patient's family, will go into trance. This shaking is caused by the bai and is taken as a sign that the ghost is anxious to reveal its identity. Once that person (called the daangri) goes into trance, a jhankri will be called in and the bai will be urged to reveal who he (or she) is, why he has caused the sickness, and what must be done to appease him. Eventually, the bai will speak and reveal his identity and the necessary method of propitiation. Very often this includes the building of a small temple (baithan) the sacrifice of a goat or chicken, and periodic worship.

A pichash, like a bai, is a "ghost, goblin".⁹ Unlike the bai, however, the pichash is not the result of a body having been touched after death. Rather, it is the ghost of someone for whom the proper funerary ritual had not been performed. Again unlike the bai, the pichash can harm anyone in the village, not just his patrilineal kin. Further, the pichash is localized; he has his own spot in or near the village which villagers avoid at sunrise and sunset, the two times he is believed capable of doing his greatest harm. Should it be decided that a pichash is responsible for an illness, a relatively simple cure is prescribed. Food is set aside for the ghost at a cross-roads. Ghiu is then burned in the hope that it will attract the pichash. Once it is thought that the ghost has arrived, the healer will then chant a secret verse and thus cure the patient.

In addition to the witches and ghosts discussed above, there are fifty-two varieties of a spirit called vir. The invisible vir are inherently neither good nor evil; their role depends on who controls them. Should a boksi gain dominance over a vir, she can send it to cause illness. Should a jhankri control it, he can send it to protect health.

In addition to the witches and ghosts discussed above, there are fifty-two varieties of a spirit called vir. The invisible vir are inherently neither good nor evil; their role depends on who controls them. Should a boksi gain dominance over a vir, she can send it to cause illness. Should a jhankri control it, he can send it to protect health.

The determination of whether an illness is caused by a jaasu can be made by almost any of the village healers. Jaisi Brahmins can make the diagnosis and, if a god is involved, prescribe the correct worship (puja). But for a variety of reasons, the villagers of Dumre only rarely consult with these healers. First, the nearest Jaisi lives two villages away. Second, should it be found that a boksi or bai is responsible for the sickness, the Jaisis, because they do not go into trance, are often unable to follow through on a cure. Finally, Jaisis are often ignorant of such practices as reading the pulse and are unfamiliar with herbal remedies.

Baidhyas, because they can operate on both the herbal and ritual levels, are in greater demand than the Jaisis. How they perform diagnoses and initiate cures has been described earlier. In cases of jaasu-related illnesses, their medical kit consists primarily of secret verses (mantras). How these mantras are used, i.e. the form of the cure, varies greatly. Assume, for example, that it has been determined that a pichash is responsible for a certain patient's stomach ache. While one baidhya might say his mantra into a glass of water and then feed it to the patient,¹⁰ another might blow it directly onto the patient's stomach, all the while hitting him with a small broom. Another method is to blow the verse into rice which is then cooked and eaten. Alternatively, I saw one case in which a Muslim baidhya treated a Newar's upset stomach by blowing into a bottle of raksi. Mantras can be in any language - Nepali, Hindi, Urdu, or Arabic - and some baidhyas even have verses in a secret language understood only by them.

Yet when it comes to the exorcism (jhaarphuk) of spirits, baidhyas operate under a severe limitation. Since they do not go into trance, they are unable to consult with the gods and pinpoint the cause of the illness. Knowing that a boksi is at the root of the problem is the necessary first step. But being able to determine who that boksi is, why it has made the patient ill, and what must be done to propitiate it, are the essential elements of a permanent cure. Where the illness is due to the action of a pichash or weaker boksi, the mere blowing of a mantra may be sufficient. But in cases of severe illness involving a bai or a powerful boksi, baidhyas, because they cannot make the crucial specific diagnosis, can at best offer only a temporary alleviation of the pain. One jhankri maintained that if a person has been made sick by a boksi (boksi laagyo) and comes to him within ten or twelve days after the onset of the illness, then a mantra blown into water would in

itself be sufficient; but if the patient were to delay visiting him and allow the illness to become well-advanced, then full treatment, with trance and possession by the gods, would be necessary to complete the cure.

The ritual healers par excellance are the jhankris. In Dumre there is only one jhankri, a Damai. There are others nearby, however, and the villagers have a pool of five or six to choose from. Each has his own specialty - i.e. one is reknowned for his ability to exorcise boksis, another for his experience with bais - and the villagers choose their shaman on that basis. Unlike the jaisis or baidhyas, jhankris are capable of making a precise identification of the witch or ghost.

The power of the jhankri stems from his ability to communicate with and control the spirit world. Despite the great variety of illnesses with which the jhankri must deal, all healing ceremonies (aushadhi garnu; lit., "to do medicine") follow essentially the same pattern. First, the shaman will use his gyaan to establish contact with, and become possessed by, the gods. Which god (or gods) he calls (jhiknu; lit., "to pull out") is strictly a matter of choice; each shaman has his favorite god whose counsel he values and trusts. Very often the advice of only one god will be needed. Occasionally, however, the complexity of the illness or the refusal of the offending spirit to leave will demand consultation with several deities. At one healing I attended, the jhankri was possessed by, and received conflicting advice from, five gods. Once the jhankri has become possessed, he will summon the spirit responsible for the illness and demand that it possess the patient. After the patient has gone into trance, the jhankri will leave his trance and question the spirit: "Are you a boksi? Are you a bai? Why have you made this person ill? What must be done to get rid of you?" At no point does the jhankri ask the spirit its name; rather, only by indirect questions (e.g. "How many sons do you have?" "Are you a Chhetri or a Damai?" "Is you home north or south from here?") does the jhankri gain enough clues to learn its identity. Jhankris claim that demanding the spirit's name would cause unnecessary offense and make the cure more difficult. Some villagers, however, maintain that the indirect method of interrogation and the ambiguity of the clues provide the shaman with an excuse should the cure prove ineffective. Because the initial identification of the boksi, bai or other jaasu comes from the daangri (trancer) himself, the daangri, in effect, performs a self-diagnosis. Periodically, however, the jhankri will re-enter an ecstatic state and, after a consultation with his own gods, pass judgement on the veracity of the daangri's claim. If the daangri (or more accurately, the spirit speaking through the daangri) has told the truth, then the healing will proceed to the issue of how to exorcise that spirit. If, on the other hand, the jhankri's

gods fail to confirm the self-diagnosis of the daangri, then the whole process of identifying the spirit must begin anew.

The jhankri must not only determine the cause of the illness, he must also prescribe the cure. In the case of a vir or a bai, this involves worship and the sacrifice of an animal. With boksis, however, more aggressive tactics may be necessary. It is thought that once the patient is possessed, all physical sensations are felt, not by the patient, but by the boksi.¹¹ The jhankri, therefore, often beats the daangri (i.e. the boksi) in the hope that this will persuade the witch to leave the patient for good. In the local idiom, it is said that the boksi "eats" (khaanu) its victim. To ensure the success of the cure, the shaman will sacrifice a chicken and "feed" it (in a symbolic sense) to the boksi as a substitute for the patient. If need be, the jhankri can threaten to use his own gyaan to kill the boksi's own children. The ultimate aim is to receive a promise from the witch that she will cease harming the patient, but because witches are such evil characters to begin with, no one is ever really sure whether her assurances can be believed. If the patient does not get well, it is common to blame the perfidity of the boksi. This results not in the denial of the validity of the system, but rather in the belief that stronger measures (e.g. beatings) will be necessary the next time.

To a westerner, the whole idea of spirit possession and ritual healing might appear as a rather futile exercise. And for some illnesses, such as tuberculosis or leprosy, it is. Yet it must be remembered that a great many maladies, such as stomach aches and sore throats, are self-limiting, i.e. they get better whether or not any action has been taken to cure them. Thus, a headache which was "cured" by aspirin might probably have gone away just as quickly had the patient drunk water into which a baidhya had blown a mantra - or had the patient done nothing.

But far from being a superfluous addition to an ailment's natural course, ritual healing is valuable in the treatment of certain kinds of social and psychosomatic illnesses. To demonstrate the role of the jhankri as a social broker, summaries of three case studies will be presented. As an introductory note, it is important to understand that the need for everyone "to get along" (milnu) is a strong village ethic; public accusations and fights are discouraged and the person who consistently shows his anger is labelled by the villagers as "stupid". As the following examples will show, ritual healing provides a mechanism through which private grievances may be publicly aired.

- 1) Approximately eight years ago, a woman in a neighboring village accidentally killed her son. Afraid of the consequences, her family conspired to blame another man who, after a

police investigation, was sent to prison for six years. Upon his release and return to the village, he goes into trances. A jhankri was hired and the man, while in trance, claimed that his illness was being caused by the bai of the murdered son who wanted the truth to come out. The woman's family, again afraid of the consequences, produced its own daangri who claimed, while in a state of possession induced by the jhankri, that the bai was not that of the murdered son, but rather that of a man who had gone to India generations before and had died there. Clearly, both sides were using the medium of shamanism to vindicate themselves. The parties to the conflict could have gone around the village protesting their innocence. Yet by resorting to the use of jhankris to get their message across, their arguments were not only presented in a more socially acceptable forum, but also carried the sanctions of the gods.

2) The second case involves the woman mentioned earlier who ran away when she discovered that her mother-in-law was a boksi. For a variety of reasons, the two women do not get along. Last summer the younger woman had a son but was unable to provide milk for it. Aside from nutritional deficiency, anxiety is the prime factor leading to failure to lactate.¹² Eleven days after her son's birth, at the traditional naming ceremony, the mother asked the Jaisi Brahman for a diagnosis. The Jaisi, after asking the pertinent questions, said that the illness was due to her having offended Naag (the snake god), that she would have to do puja, and that she would be able to feed her son within a week. After two weeks had passed with no improvement in her condition, she and her husband finally called in a jhankri. While the daangri was in a state of ecstasy, the spirit identified herself as the patient's mother-in-law. When the cure was finished, the jhankri assured the woman that the spirit had been exorcised and claimed that within four days she would begin to lactate. After three days the woman did, in fact, begin to produce milk in small quantities, and after a week she was able to feed the child without the need of a wet-nurse. While the timing

may have been coincidental, the more likely explanation is that psychosomatic factors (i.e. her unfortunate relationship with her mother-in-law and her trust in the jhankri) had an influence on her ability (and inability) to feed her son.

3) One night after the completion of a healing session, a young Kami girl who had been sitting there watching started to spontaneously go into trance. It turned out that the girl was being possessed by her elder brother's wife, a boksi. The spirit revealed that she wanted to kill the daangri because she wouldn't give her (the boksi) any food, because she had had sexual relations with men of other castes, and because "she is evil." On one level, it could be said that the woman was verbalizing guilt feelings. But what is of significance here was the role of the jhankri. In a cross-examination that lasted over an hour, the jhankri trapped the boksi in a logical dilemma: yes, the daangri is evil, but religion says that murder is also evil, and if the boksi killed the daangri, she (the boksi) would be as much of a sinner as the daangri. Once he got her to admit to the contradiction, the jhankri immediately changed tactics. Rather than arguing with the boksi, he sympathetically told her that everyone knew about her problems with her sister-in-law, that they all agreed that the daangri had treated her badly, and that he would speak to the daangri when she left the trance. In return, the boksi promised that she would do no further harm.

In each of these three examples, the jhankri served a different function. In the first case, he was the mechanism through which the actors expressed otherwise unexpressable conflicts. In the second he performed a psychotherapeutic function, helping the woman overcome her anxieties. And in the third example, he functioned as a social worker, arbitrating in a domestic dispute. In sum, one must view jhankris not only as practitioners dealing with physiological problems, but also as an important component of the social network. The significance of that role is recognized by the villagers as well. One jhankri complained to me that people are always trying to bribe him into naming their enemies as the boksi responsible for an illness. In one instance, a patient promised him eight chickens and fifteen bottles of raksi if he would confirm his story. Once, when I asked whether I could be boksi laagyo, the jhankri replied, "You haven't, but you could."

But why should you? You're a foreigner, you haven't made anyone angry at you, you don't have land, you don't hire labor, you don't go around criticizing people. Do you? So why should a boksi hurt you?" In effect, the jhankri was confirming the social origins of certain illnesses. And once that assumption is made, the healing process as well must operate on the social level.

It is the Hindu system of ritual healing which has been described thus far. Yet the Muslims of Dumre also have their own concepts concerning illness and curing. The most fundamental of these relates to the classification of spirits. As has been noted, Hindus believe that there are two types of ghosts - the bai and the pichash. Muslims, however, maintain that there is only one kind of spirit, the deoti. A soul becomes a deoti, not by the corpse having been touched by an animal or by the funerary rites not having been performed, rather, only a person who has died a "bad death" - either by fire, drowning, falling from a tree, hanging, or having been killed by a bear or tiger - becomes a deoti in the afterlife. Like the bai, the deoti possesses only its patrilineal kin and causes all sorts of ailments. Yet here the similarity ends. While the illness may be felt at any time and any place, the actual trance can occur only at night and only near the hearth (chuhlo) inside the house. Once it has been determined that a deoti is involved, the members of the household must clean the house and bathe, after which a Muslim curer is summoned. The healer is never referred to as a jhankri, but instead as a jaanne (lit., "knower"), a term also applied to the Hindu jhankri. The distinction between the jaanne and jhankri is more than just a linguistic technicality. What is crucial is that the Muslim jaanne does not go into trance. When the time comes for calling up the spirit and urging it to possess the patient, the jaanne merely reads the Koran and lets it be known that the deoti's presence is required. The deoti then comes and possesses either the patient or any of his patrilineal kin who are present. Yet here, too, a terminological problem arises. As noted, states of possession among the Hindus range from a simple trembling of the hand to a complete state of ecstasy. Among the Muslims, however, possession entails merely the quivering of the hands, during which time the deoti speaks through the daangri's mouth. There is never an altered state of consciousness and the man in trance can listen to what the deoti is saying, smoke a cigarette, even walk around.¹⁴ The jaanne does not have to argue and fight with the deoti as the Hindu jhankri does; it is expected that the spirit will be honest in revealing its identity and the reason it has caused the illness. Exorcism consists of a reading from the Koran and the feeding of sirni (a type of bread made from millet or rice, sugar, and ghiu) to the people present. To ensure that the deoti does not return, the jaanne may make a palita (a written amulet similar to the Hindu jantar but which contains verses from the Koran).

When asked what happens to a person's own mind while in trance, one jaanne replied, "Nothing happens, the deoti just speaks through his mouth. Hindus are afraid of their gods (deota). Ours do absolutely nothing." He then went on to explain that under some circumstances, the Muslims even ask a deoti to possess a healthy person. If, for example, an object has become lost, it is believed that a deoti has the power to come and reveal where it may be found.

The Muslims, therefore, have their own ideas about spirit-related illnesses and cures. One fascinating question concerns the relationship between the Hindu and Muslim systems. When asked to comment on the healing practices of the other group, both Hindus and Muslims expressed doubts about their effectiveness. One Hindu stated that he could not understand how the Muslim jaannes could cure patients if they neither went into trance nor sacrificed chickens. A Muslim, on the other hand, summed up his opinion of jhankris by saying, "I'll tell you what they do. They call up all kinds of devils and then they fight those devils with their own. Then, they tell you they need a chicken. And they need rice. Then they eat the chicken and the rice. It does nothing." On this level, therefore, it would seem that the two groups have no respect for each other's medical systems.

But when an examination is made of what the members of both communities actually do, the picture changes radically. Because the Hindu bai can harm only patrilineal kin, they are of no concern to the Muslims. But boksis, pichash, masaan, and vir can harm anyone, and despite claims by the more orthodox to the contrary, the Muslims of Dumre believe very strongly in their power and readily admit to it. In effect, they have integrated elements of the Hindu spirit world into their own belief system. On the one hand, Muslims claim that the form of trance experienced by the Hindu jhankris is inspired by the devil (shaitaan); in dealing with the deotis the jaannes do not need to enter a state of ecstasy. On the other hand, however, Hindu concepts of ritual medicine are based upon the premises that the jaasu themselves cause people to go into trance and that only through a trance can a proper cure be initiated. And for the Muslims, this poses a dilemma - how can you justify the regular use of a practice which is both recognized as necessary and condemned as satanic? For the majority of Muslims the problem is resolved by employing both the Muslim jaannes and the Hindu jhankris. For minor exorcisms, the jaannes read the Koran and say their mantras. Should the cure be unsuccessful, however, they will then hire a jhankri to go into trance and consult with the gods. From the Muslim point of view, the integration of the two systems is demonstrated by the fact that one day the religious leader (wastaj) of the Muslims said that he was suffering from a headache caused by a pichash - and that he had received the diagnosis from a Jaisi Brahman.

The Hindus, for their part, have incorporated Muslim elements into their healing strategy. Some of the Hindus value Muslim mantras more than those of their own jhankris and baidhyas. The reasons given for the preference were vague, but one high-caste Hindu said that he believed the Arabic mantras were more effective because he could not understand them. One jaanne had a different explanation, based on his perceptions of the relative hygiene of the Hindus and Muslims. "We rinse ourselves after we defecate; the Hindus don't. How can mantras work if you are not clean?" If the Muslim healers fail to cure, the Hindus will resort to a jhankri. But what if the patient's health still does not improve? In some cases, those with enough money make a pilgrimage to dargah, just across the border from Raxaul. What is significant (and surprising) is that dargah is a Muslim holy place.¹⁵ According to one Hindu who had just returned from there, the cure consists primarily of a session with a Muslim "jhankri" who, while in a trance, commands the patient to "throw off" the spirit. A Muslim jaanne, on the other hand, insisted that the healer does not go into trance; rather, it is the mere holiness of the place which exorcises the jaasu. In any case, the patient who wishes to be cured must sacrifice a chicken to Allah and donate money and rice to the shrine. One Hindu, when asked whether he felt uneasy about engaging in what was essentially worship to the Muslim god, simply said, "It works."

Before discussing the role of western medicine in the village, it would be beneficial to briefly summarize the arguments presented thus far. In one sense, there are various levels of medicine (herbal, ayurvedic, ritual) and various kinds of healers (baidhya, jhankri, Jaisi, jaanne). Yet all of these components are integrated into a complete and interrelated system. The method of diagnosis is the same regardless of whether the illness is caused by too much sardi in the body or by a boksi. Further, both herbal and ritual cures are used simultaneously. For example, a patient undergoing treatment by a jhankri will often ask the baidhya for medicine to alleviate the painful symptoms; similarly, a person with, say, a cut might ask the ritual healer for a mantra to protect him from spirits (see below). Jhankris are familiar enough with herbal medicine to prescribe the leaves and roots of various plants; baidhyas have the mantras to perform minor exorcisms (indeed, the three Muslim baidhyas are also jaannes); and Jaisis can diagnose the illness and send the patient to the appropriate specialist. In sum, while there are spheres of medicine, they all operate within the context of a larger system.

The United Mission to Nepal hospital at Ampipal, situated one hour's walk from Dumre, has been in existence for approximately seven years. With a staff of three doctors, several western nurses, and a large staff of Nepalis, the hospital is equipped with an x-ray machine, an operating room, an out-patient clinic, a laboratory, and a well-stocked pharmacy. Just as important as

the facilities it offers, however, is its approach to medicine. Basic understandings about the nature of illness, the methods of diagnosis, the techniques used in treatment - all are western in orientation. There is no discussion of boksis or mantras, and patients are never referred to a baidhya or jaanne. In short, the medicine offered at the hospital varies greatly, both in philosophy and content, from that of the village healer. The doctors and jhankris operate under different assumptions and each is more than a little mystified by the practices of the other. On that level, it would be tempting to say that the two types of curing represent separate and irreconcilable systems which are competing for the attention and loyalty of the villagers.

Yet from the villagers' point of view, the problem is not one of opting for one method at the cost of repudiating the other; instead, it is one of deciding which form of curing is more effective given a specific illness. The villagers have had enough experience with both the hospital and the baidhyas to have developed a certain amount of sophistication about their relative effectiveness and limitations.

Before discussing when, and for what ailments, the people go to Ampipal, it is necessary to explore village attitudes towards the hospital. Among the Hindus and Muslims, there is a strong ethic in favor of doing "good works" (raamro kaam) for the purpose of religious merit. People assume, therefore, that the missionaries have come to Nepal for the same reason and there is the underlying feeling that by going to the hospital they are doing the missionaries a favor by allowing them to acquire their own form of religious merit. There is also an economic side to the hospital: for many people it is a place where menial jobs are paid well, where agricultural surpluses can be sold, and where academic scholarships are provided to those who believe (or profess to believe) in Christianity. Just as crucial is the fact that, for the Nepalis, the hospital is a symbol of the wealth and development of the western world and, by implication, the poverty and underdevelopment of their own. One night, while sitting outside, one villager looked across the valley to the electric lights at the hospital and remarked, "It would be so nice if we could have lights like that here. But we're so backward, what can you do?"

The villagers often express more specific attitudes about the hospital which have a bearing on whether or not they go there for treatment. A common complaint concerns the amount of time they have to wait - to get their card, to see the doctor, to pay, to pick up the medicine. Unless the out-patient clinic is exceptionally busy, the patient can be back home by the early afternoon. Yet regardless of how long it takes, he is still in the position of having to lose a day's wages or neglect his fields. The clinic operates efficiently, but when comparison is made with the baidhya, whose diagnosis and cure can take five minutes, a visit to the

hospital is inevitably seen as a long, wearying process.

Another factor working against the hospital is its cost. By American standards, medical care at Ampipal is amazingly inexpensive - Rs. 20 for a chest x-ray, Rs. 1 for thirty aspirin, and Rs. 2 for laboratory tests.¹⁶ Yet by the time the various bills have been added up, the total cost can sometimes reach as high as Rs. 30 and 40 - a considerable sum for a peasant who earns an average of four rupees a day, baidhyas, on the other hand, do not take any money, and jhankris charge approximately Rs. 15 to 20 for their work. Of course, should prolonged and complicated treatment be necessary, both jhankri and hospital expenses can be extremely high.

A third consideration concerns itself less with the actual operation of the hospital than it does with the villagers' expectations of western medicine. Cures should be immediate and any illness which does not improve right after the "eating of medicine" (aushadhi khaanu) confirms the views of some that the hospital is just a waste of time and money. The problem is exacerbated by the fact that as soon as an improvement is noted, the patient will stop taking the medication. And then, should the illness recur or fail to go away completely, the blame is often placed on the hospital. Finally, to the villager's way of thinking, the methods of diagnosis at the hospital do not always meet the standards set by the baidhyas. As mentioned previously, the fact that the baidhyas read the pulse in both wrists makes the doctors' reading of one wrist seem incomplete. Further, because the villagers believe that the stethoscope should be placed on the stomach, not the heart, some people are skeptical about the care they receive at Ampipal.

In the majority of cases, treatment at the hospital is sought only after village cures have been attempted. Given the fact that the baidhyas' services are cheaper, faster, and closer than the doctor's, it is only logical that villagers should seek out the local healer first. But more than just convenience, the village healer has the advantage of being able to deal with spirits. One informant stated that, "Hill people always think that all illnesses are caused by jaasu. It's like their first aid." Doctors operating under western concepts are viewed as unequipped to deal with boksis and any illness involving trance is immediately brought to the attention of the jhankri. The ritual side of medicine is never mentioned to the doctors in the belief that "they just wouldn't understand" or that "they would laugh at our ignorance." One man whose wife had been in trance declared, "If it was an upset stomach, I could take her to the hospital. If it was TB, I could take her to the hospital. But it's not an upset stomach and it's not TB, so what's the use of taking her to the hospital?"

Yet the fact remains that the villagers do go to the hospital. When asked to list those illnesses which they thought were best treated at Ampipal, people gave various responses. One young

Chhetri claimed that only cuts, fevers, and broken bones should be taken to the clinic. A Muslim jaanne placed worms, cuts, and burns in his list but then added that stomach problems should be included, should the medicine of the baidhya fail. The jhankri maintained that for sickness not involving spirit "the hospital has won" but that "the hospital can't cure illnesses caused by jaasu."

A model consisting of spirit-nonspirit, jhankri-doctor dichotomies, however, would be too simple to explain how the villagers manipulate the medical options available to them. On both the practical and conceptual level, western medicine is integrated into the village system. One example might serve to demonstrate how different strategies are employed in the curing process. In early 1975, the owner of the teashop began to suffer from severe abdominal pains. One person who had been sitting there decided that it must be constipation and, after lying him down on the floor, started to rub mustard oil onto his belly. After ten minutes his stomach began to rumble and this was interpreted as a good sign. He was then fed three packets of a worm medicine manufactured in India, after which a towel was tied around his waist as tightly as possible in the hope that that would get his bowels moving. After an hour his condition still had not improved, and when he began to vomit it was interpreted by the crowd that had gathered as a sure sign that he was boksi laagyo. A Muslim jaanne arrived and blew mantras on him, all the time waving the air over his stomach with a sickle and hitting him with a small broom. He finally said a mantra into water and had the patient drink it. By evening he was still in pain and discussion turned to whether or not he should be taken to the hospital. One group favored carrying him to Ampipal immediately, another recommended calling in a jhankri to exorcise the boksi, and yet another group thought that it might be best just to sit tight and hope that it got better by itself. In the end he was carried home and a jhankri was summoned. The jhankri did not go into trance, but he did confirm the earlier diagnosis that a boksi was responsible. He too blew mantras and wrote out a jantar for the patient to wear. Two days later, after he had begun to feel better, the patient went to the hospital where he had a full examination and was given an injection and pills. Within a few days he was back working in the teashop. Whether the cure had come from the jhankri, the hospital, or whether the teashop owner would have gotten better anyway is irrelevant for this discussion. What is important is that all medical possibilities were tried.

It was stated earlier that if a person's illness involves trance, hospital medicine is considered useless. Yet should a jaasu cause others forms of sickness, such as stomach pains or fever, then while only a jhankri can initiate a final cure, the hospital can alleviate the pain. For example, a fall from a tree might be explained as having been caused by masaan entering a person's brain and making him dizzy; yet it is generally agreed

that the resulting broken arm is best taken care of at the hospital.

An important theme running through many of the villagers' discussions about medicine is the previously noted belief that any ailment, however minor, gives a boksi the opportunity to cause additional suffering. Throughout the research period I was constantly being asked to bandage cuts. The need arose not from a fear of complications due to bacteria, but rather from the fear that an open wound would be an invitation to a boksi to increase and prolong the pain. What is interesting is that western medicine (in this case antiseptic ointment and band-aids) is seen as a means of prophylaxis against the spirit world. One young man went so far as to say that the hospital serves as a sanctuary within which the jaasu cannot enter. Everyone else I spoke to disagreed with this claim and explained the advantage of western medical practice in such terms as, "If you take hospital medicine you get better faster and the boksi has less time to make you sick." If there is the suspicion that a boksi (or other jaasu) has already begun to work to the patient's detriment, a ritual healer will be asked to provide the necessary mantras or jantar. One man who had been stung by a wasp went immediately to the hospital for treatment; yet when his arm continued to swell up he had a baidhya blow a mantra onto the affected area. Another person who was being treated for tuberculosis at the hospital had a baidhya come every day, not because he thought that his disease had been started by a boksi, but because he did not want a boksi to take advantage of his condition.

Village and western systems of medicine, therefore, do not operate at the exclusion of the other. From the patient's point of view, the building of the hospital merely increased the options available to him. Which form of curing he will seek depends on many factors - education, wealth, previous experience, pressures from family and peers, age, and travel, among others. It also depends to a great extent on his own perceptions of the nature of illness. For example, when a "crazy" (bolaha) woman from a nearby village came through Dumre, some people explained her condition as being due to two jaasu possessing her simultaneously and fighting for control of her mind; others maintained that her mental illness was the result of her brain having "dried out" (gidi sukyo). Which cause is believed by her kinsmen to be the most accurate will obviously have an effect on which form of curing is sought.

In the final analysis, medicine is based upon faith - faith in the ability of the healers, faith in the methods of curing, and faith in the philosophy and cosmology upon which the system is built. A westerner unfamiliar with village curing practices would undoubtedly look upon the trance of the jhankri with amused horror. Similarly, the increase in hospital visits over the past seven years¹⁷ is indicative of the faith the villagers are increasingly placing in the hospital.

No system of medicine can guarantee a one hundred percent rate of cure. A patient in the west whose condition does not improve does not resolve that he will never again enter a hospital. Rather, he might ascribe the failure to the incompetency of the doctor, to a faulty diagnosis, to a malfunction in the testing equipment, to the prescription of the wrong medicine, or to his own failure to strictly follow the doctor's advice. All sort of excuses are built into the system and rarely will the patient throw up his hands and repudiate all that he had previously thought of as "proper medical care."

The villager as well has means for rationalizing medical failures. It is possible, for example, that the leaves he picked were too dry to be effective. Or perhaps the baidhya had made a mistake in the reading of his pulse or the recitation of his mantra. If the healer had been a jhankri, it may have been that the boksi had lied when she said she would leave, or the jhankri may have consulted with the wrong god, or more probably, the boksi's gyaan was stronger than that of the jhankri. As with the western patient, faith is never shaken in the basic validity of the system.

One day a villager came to me and told me that his wife had been menstruating for over a week and that he was going to call in a jhankri to cure her. The following morning I asked if she had gotten better and from a western point of view, his response was strange: "It's too early to tell. If she gets better, I'll take her to the hospital. If she doesn't get better, I'll go back to the jhankri." One would have expected him to say the reverse - that if one method had failed, he would have tried the other. But in this case his faith lay primarily with the jhankri, and the hospital was seen as playing only a supplemental role.

If there is one point to be drawn from the data presented, it is that the Nepali villager's concepts of medicine are not a tabula rasa upon which westerners can freely impress all sorts of notions about viruses and antibiotics. Nor is the problem one of finding ways of replacing village methods with more "scientific" ones. While the hospital unquestionably has much to offer in the treatment of diseases, it could never pre-empt the psychotherapeutic role of the jhankri. If health care in Nepal is to be improved, one must start with the assumption that the villagers' faith in their own healing techniques - be they herbal or ritual - is not going to be shaken by the occasional visits of medical teams or even by the building of hospitals. The problem facing the public health worker is one of finding the means of integrating western ideas into the village system. From the villager's point of view, the process has already begun.

FOOTNOTES

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²Baidhya is often translated as "doctor." Yet the inhabitants of Dumre reserve that term for the practitioners at the hospital, not for the village healers. The same distinction will be kept here.

³See, for example: Devkota, Kosnath. 1969. Nepalinighuntu: Anek Bhasha-Sangrahasahit. Kathmandu; Devkota, Rammin Acharya. 1972. Saadhaaran Chaltiko Aushadhi ra Gharelu Aushadhi. Kathmandu; Sharma, Purna Chandra. 1974. Aushadhi Purna Chandrodaya. Varanasi.

⁴It is unlikely that the informant meant cholera in its western usage. Many western names for diseases (e.g. typhoid, malaria) are applied to any number and type of illness. Similarly, any injections given at the hospital, be it anti-biotics or vitamins, is referred to by the villagers as "penecillin."

⁵For a list of such medicinal plants, see: HMG, Ministry of Forests. Department of Medicinal Plants. 1970. Medicinal Plants of Nepal. Bulletin of Department of Medicinal Plants: No. 3. Kathmandu.

⁶Giving exact parameters to the definition of "trance" still remains a basic problem in anthropology. While some might base it on a presumed altered state of consciousness, others might insist on the reading of physiological indicators. I am not concerned here with a psychophysiological definition of "trance;" rather, I am subsuming under the term all those forms of behavior which the villagers themselves would refer to as a trance state. In other words, the definition used here is emic, not etic.

⁷Turner, Ralph Lilley. 1931. A Comparative and Etymological Dictionary of the Nepali Language. London: Routledge and Paul Ltd. p. 496.

⁸Hitchcock, John T. 1967. "Nepalese Shamanism and the Classic Inner Asian Tradition" History of Religion 7: 149-158. Quoted from page 157.

⁹Turner, op. cit., p. 379.

¹⁰Rather than "saying" their mantras, baidhyas "blow" (phuknu) them. The term refers to the fact that after each verse, the healer emits quick whistle-like noises which help transfer the power of the mantra to the object being blown on. It is commonly believed that the efficacy of the mantras lies not only in the words said, but also in the breath of the healer.

¹¹Needless to say, the boksi herself does not attend the healing session; rather it is her spirit which comes and possesses the patient.

¹²Cf. Cambell, E.J. Moran, C.J. Dickinson, J.D.H. 1968. Clinical Physiology. Oxford: Blackwell Scientific Publications. p. 621.

¹³Haapij and molaanaa are, respectively, the Urdu and Arabic words for these healers, but in fact, I never once heard them referred to by these terms. Also, although jhankris are also called jaannes, I will retain for the purpose of clarity, the Hindu-jhan-kri, Muslim-jaanne dichotomy.

¹⁴Again, some anthropologists may argue that this is not a true state of possession. But as before, the term "trance" is being used emically and the villagers themselves refer to it as a trance state.

¹⁵Dargah is not the name of a specific town or village. Rather, it is "a respectful term applied to the shrine of a Muslim saint in India. In spite of the Prophet's disapproval of building tombs, great reverence is paid all over the sub-continent to such tombs. The word dargah often includes a group of buildings of which the tomb is the nucleus." Fyzee, Asad A.A. 1974. Outlines of Muham-maden Law. 4th edition. Delhi: Oxford University Press. p. 327.

¹⁶Current exchange rate is Rs. 12/45 NC to \$1 US.

¹⁷Dr. Tom Hale, personal communication.



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notes on two shaman- curers in kathmandu

Ferdinand E. Okada

Despite the advance of modern medicine in Nepal the role of the shaman as folk curer remains strong.¹ In a survey of 19 village panchayat areas² (a collection of rural settlements into one administrative area), not one was without its shamanistic curer who went under such various names as jhankri, dhami, janne or jhar-phuke. While these appeared to depend greatly on the exorcism of possessing spirits to cure diseases, there were, in addition, practitioners of a perhaps more rational or scientific system (from the western viewpoint) who depended on the curing properties of traditionally known herbs and plants.

Of those who may be broadly grouped as shamans an estimated 600 were said to be present in these 19 village panchayat areas, serving a population of some 67,000 (in 1971). The vast majority of them, however, did not seem to engage in their calling on a full-time basis; that is, for most of them subsistence farming was apparently the primary source of livelihood and curing was a secondary occupation from which they made a little extra income in cash and in kind (rice, meat, cloth). Their significance lies in their numbers and in their ubiquitous presence.

Also found in the same areas were 39 baidya (traditional doctors), 14 compounders with some knowledge of modern medicine and, of government-trained personnel, two health assistants and one nurse.

Eight of these areas had relatively easy access, within two hours' walk, to a modern hospital, clinic or health post. This access to modern facilities does not appear to have displaced shamanistic curers. In one instance, ten were found within 20 minutes' walk of a well-equipped and well-staffed hospital; in another area served by a health post and also with fair access to several hospitals, 98 were found in a population of 7,000. Shamans live within urban Kathmandu and this paper is concerned with the details of the curing-practice of two of them.

While it is true that people readily avail themselves of modern medical facilities and services, whenever and wherever possible, seeing a shaman or going to a hospital (or to a baidya or a doctor, for that matter) are not mutually exclusive acts. In many instances an ailing person goes, or is taken, to a shaman first, then to a hospital if he feels he has not improved. He may again go back to the shaman. This time lag before receiving adequate modern medical care can be serious, of not fatal, in a number of cases.

In order to obtain more detail on the role of the shaman as folk curer, attempts were made to establish rapport with several in urban Kathmandu. Of the half-dozen or so who were willing to talk in general terms about their profession, two turned out to be willing to disclose details of what may be called their "case books" and be observed on occasion. One was known as, and called himself, a dhami, the other, a jharphuke. The working assumption that these two terms were synonymous turned out to be wrong in detail. Thus the various terms, including janne and jhankri, may all refer to different types of shaman-curers to a greater-or-lesser degree.

Both the dhami and the jharphuke are Tamang in ethnic origin (though, as far as is known, there are no caste or ethnic restrictions on becoming a shamanistic curer, it is suspected that certain groups have a proclivity to it) and both are part-time practitioners. The dhami is a low-ranking civil servant and the jharphuke is an entrepreneur who rides about the streets of Kathmandu selling loaves of bread from a tricycle van.

The Dhami (See Appendix I)

The dhami is a 28-year old Tamang from a village on the northern periphery of Kathmandu Valley. As a child of twelve, while at play, he said, he fell down unconscious for some unknown reason and was carried to a dhami (another Tamang) who restored him to his senses. The older man told the boy that this loss of consciousness was a sign from God that he was being summoned to become a dhami and that it would recur unless he acquiesced. Being frightened, the boy began his training on an auspicious day with the dhami and, along with the secrets of the profession, he was given his own mantra (magic incantation). He started practising as a dhami at the age of twelve.

The dhami is married, has three sons (none is in school though old enough) and rents the ground floor of a small two-story house in a rather unfashionable section of Kathmandu. His job in government probably brings him about Rs. 200 a month, but he regards his work as a curer, which brought him Rs. 116.50 in the month of Marga, 2032 B.S. (17 Nov.-15 Dec., 1975), as his primary occupation.

During that month he had ten patients, six of whom came to his home. He went as far away as Thankot and Bhaktapur (approximately 10 km to the east and west, respectively, of Kathmandu City) for four more, being called for in a taxi or rickshaw by the relatives of the patients. Almost all the fees he earned in Marga came from these four : Rs. 107 and, since for three of them a goat sacrifice was involved, some meat to take home. He also, of course, received some food and drink during these "house calls." No set fee, however, is asked from any patient; they pay according to their means. Fees received ranged from 50 paisa to 50 rupees during the period under discussion.

Seven of the ten cases were explicitly stated to be the result of some form of witchcraft or spirit possession. Three included the sacrifice of a goat at temples near the patients' home and in three more cases (including two where witchcraft was not specified), the disease was transferred, with incantations and drumming, to the skulls of dogs which were later buried at a crossroads. In one case the disease was transferred to an egg. All involved the administration of herbs, curd and/or water over which a mantra had been muttered.

The herbs are kept on a dog's skull in the dhami's home before he uses them. Among other equipment he uses are the feather of a peacock, the prickly spine of a porcupine, the ringed, curved short horn of a goral, a round deer-skin drum, an iron trident (symbol of the God Shiva) and a sacred book of mantra. He also has three assistants (two Tamang and one Chhetri) who are called in when complicated and difficult curing rituals are undertaken.

One other piece of equipment is a plate made of charesh (antimony?) on which the dhami drops a handful of whole dry rice grains as he mutters his incantation. Depending on specific parts of the plate on which the grain falls and their position, he reads the physical condition of the patient. He also feels the pulse of the patient and these two acts, he claims, can tell him the nature of the disease. In more elaborate rituals, he can identify and exorcise the possessing spirit which can include more elaborate rituals such as the lighting of large sacred fires. In one instance where a goat was sacrificed to the witch because it demanded either a four-legged (goat) or two-legged (human) life, the witch was identified as the elder sister-in-law of the patient. It should be noted that witches in Nepal are believed not necessarily to be malicious but, willy-nilly, can endanger relatives and friends. Once a witch is propitiated it is said that the danger to the particular victim is ended. It should also be noted that a right angle crossroad is considered to be particularly dangerous, being a spot where evil spirits are thought to congregate at night.

The patients of the dhami - he considered ten to be a normal number of cases for him for a month - was comprised of four males and six females ranging in age from one year to 50. In ethnic/caste background, there were one each of Chhetri, Magar and Tamang, two Brahmin and five Newar.

The Jharphuke (See Appendix II)

The jharphuke is a 56-year old Tamang from Kavre Palanchok District, immediately east of Kathmandu Valley, the only son of a man who was himself a jharphuke. Taught by his father, he started practising his calling at the age of thirteen in his home district.

He is married and has one son and three daughters, all of whom are in school. He has rented the top floor in a three-storied house in a suburb of Kathmandu. During the day he engages in what he considers his primary occupation: the selling of loaves of bread from a tricycle van with which he plies the streets. The bread is obtained from a bakery and is sold at about Rs. 1.50 a loaf depending on weight, a profit of five paisa (he says) on each. In any case, re-loading his tricycle as necessary, a good day may see a profit of Rs. 50; more usual is a profit of Rs. 20 or Rs. 25 daily. It is not surprising that he can afford to educate formally all his children.

During the month of Poush, 2032 B.S. (16 Dec., 1975-14 Jan., 1976) he saw 20 patients, which he considers a normal number for a month, and got cash fees totalling Rs. 154. Fourteen patients who called on him paid a total of Rs. 57. He called on six patients, getting the remaining Rs. 97. As with the dhami, the jharpukhe asks no set fee and the patients pay according to their means. The highest fee received during the month was Rs. 50 (from a patient in Kirtipur on whom he had ten "house calls" over a period of a fortnight) and the lowest was Rs. 2.

Three of his 20 cases involved possession by a spirit. The remainder ranged from pitta ko rog (hepatitis) through headache to a nose-bleed. In all but four cases, the main treatment consisted of the muttering of an incantation which he blew over the body of the patient, sometimes in short quick puffs, sometimes as a long exhalation. Mantra were also blown over herbs, water or amulets which were, on occasion, prescribed. Restrictions on the eating of fish, meat or oil were placed on those suffering from pitta ko rog, ghau khatira (boils and ulcerations) and jwar (high fever).

In contrast to the dhami's treatment of spirit possession, those three patients of the jharpukhe possessed by a spirit of a serpent (nag lageko) or a god (deuta lageko), got no more than the blowing of a mantra over their bodies. The jharpukhe claims, however, that he knows how to exorcise a witch (bokshi bakaune) after the fashion of a dhami and does so if it becomes necessary. It was, he says, a part of his training. Indeed, his equipment duplicates that of a dhami in some respects: sacred book of mantra, prickly spine of a porcupine, the horn of a goral and a drum. In addition, he has a sacred string of beads, a bell, some bones of a snake and a thurpi, a trowel-shaped wooden symbol of power. He has no peacock feather, trident or skull of a dog as found with the dhami. He has no assistants. It is probable, however, that the dhami's trident and the jharpukhe's thurpi, for example, serve the same function.

The jharpukhe's patients were comprised of eleven males and nine females, ranging in age from six years to 40. In caste or ethnic background they were eight Newar, seven Tamang, three Brahmin and two Chhetri. There appears to be no significance in the

Appendix I. The "Case Book" of the Dhani for the Month of Marga, 2032 B.S.

Note: Water, herbs (kept on the skull of a dog) and curds and amulets have the dhani's mantra blown over them.

Abbreviations and symbols: X = Yes M = Male B = Brahmin N = Newar
F = Female C = Chhetri T = Tamang

S.N.	Diagnosis/Symptoms	Treatment	Age	Patients Sex Caste	No. of Visits	Seen at dhani's home	Total cash fees (rs.)
1.	Sukenas (daily loss of weight, growing pallor, loss of appetite).	Herbs before morning meal for 3 days	16	M M C	3	x	3
2.	Sukenas	Herbs and curds for 1 day. Amulet for 5 mos. Disease transferred to skull of a dog, later buried at a crossroads. No black dal for 9 days.	6	F N	1	x/	1
3.	Sukenas	As above.	1	M N	1	x	1
4.	Khana ma kuphat pareko (eating of bewitched food; stomach pains)	Water before meals for 3 days. No black dal and meat for 7 days.	15	M N	2	x	3
5.	Bokshi lageko (possessed by a witch; paralysis)	Herbs for 1 day. Amulet for 6 mos. No curd, meat, black dal for 7 days. Disease transferred to an egg.	3	F N	1	x	0.5
6.	Bokshi lageko	Herbs for 1 day. Amulet for 3 mos. Goat sacrificed to propitiate the witch.	30	F T	1	Thankot	50
7.	Bokshi lageko (trembling and muttering)	As above.	40	F B	1	Thankot	30
8.	Bokshi lageko (loss of appetite; constant crying)	Herbs for a day. Disease transferred to skull of a dog, later buried at a crossroads.	1	F N	1	Bhaktapur	5
9.	Deuta lageko (possessed by a god; giddiness, feverishness)	Water for 1 day. Amulet for 5 mos. Goat sacrificed at god's temple.	50	M Magar	1	Kathmandu	22
10.	Bhut lageko (possessed by a ghost; giddiness)	Curd and water to be taken once a day before main meal on 3 alternate days. Meat to be taken for 3 consecutive days.	3	F B	1	x	1

Appendix II. The "Case Book" of the Jharphuke for the month of Poush, 2032 B.S.

Note: Water, herbs and amulets have the jharphuke's mantra blown over them.

Abbreviations and symbols: X = Yes M = Male B = Brahmin N = Newar
- = No F = Female C = Chhetri T = Tamang

S.N.	Diagnosis/Symptom	Blowing over body	Treatment		Age	Patient		No. of Visits	Seen at Jharphuke's home	Total cash fees (Rs.)
			Other	Other		Sex	Caste			
1.	Kapal dukheko (headache)	x	-	-	15	M	N	3	x	4
2.	Mutu dukheko (heart pains)	x	Only milk for 7 days.		25	F	N	3	x	3
3.	Jwar ayekeo (high fever)	x	No fish, meat and oil for 7 days.		25	M	N	4	x	5
4.	Jwar ayekeo	x	As above.		30	M	T	4	Baneshwar	7
5.	Natri phuteko (nose bleed)	x	-		6	F	N	1	x	2
6.	Chau khatira/ (boils & ulcerations)	x	Water for 2 days. No fish and meat for 7 days.		10	F	B	2	x	2
7.	Phulo pareko (cataract?)	x	-		12	F	B	3	x	10
8.	Pitta ko rog (hepatitis?)	-	Water for 2 days. No oil for 7 days.		30	M	N	2	x	6
9.	Pitta ko rog	-	As above.		16	M	B	2	Kathmandu	5
10.	Jiu machalne (paralysis?)	x	-		12	F	N	4	Kathmandu	20
11.	Jiu machalne	x	-		26	M	T	4	x	7
12.	Jiu khane rog (tuberculosis?)	x	Herbs for 15 days.		20	M	T	10	x	5
13.	Jiu khane rog	x	As above.		40	M	N	10	Kirtipur	50
14.	Sukenas (daily loss of weight)	x	Amulet for 6 mos.		10	F	T	3	x	3
15.	Khana ma bigar pareko (food poisoning?)	-	Water and herbs for 1 day.		7	M	C	1	x	2
16.	Khana ma bigar pareko	-	As above.		10	M	N	1	Kathmandu	10
17.	Bahulaeko (insanity)	x	Amulet for 6 mos.		17	F	C	2	x	3
18.	Nag lageko (possessed by a serpent's spirit)	x	-		40	F	T	1	x	2
19.	Deuta lageko (possessed by a god)	x	-		30	M	T	2	x	3
20.	Deuta lageko (possessed by a god; insomnia and loss of appetite)	x	-		25	F	T	2	Lalitpur	5

ethnic/caste background of these, and the dhami's, patients except to show their catholicity. Nor is there any significance to be drawn in a small sample of 30 total patients regarding age-groupings or sex ratio.

The jharphuke met his 20 patients 64 times and the dhami his ten patients, 13 times. Breaking down the total fees on a visit basis, the dhami was paid over three times as much as the jharphuke. And the dhami also received meat on three occasions.

Concluding Remarks

Though the dhami and the jharphuke may both be classed as magic curers, they represent different types, or sub-types, of shamans. The difference is due to methods of treatment of patients and is implicit in the jharphuke's statement that he can also use a dhami's method of exorcising witches. The dhami also more specifically attributes disease to witchcraft and is more of a specialist than the jharphuke whose patients, at least in this sample, showed a wider variety of symptoms.

It is not known how many shamanistic curers are to be found in urban Kathmandu, but an estimate of 150-200, based on their presence in certain neighborhoods is probably not far from the mark.

Given the scarcity of trained personnel in the modern medical services of Nepal, it may be worth considering ways to involve shaman-curers in a program for national health improvement. Because the jharphuke is more of a generalist than the dhami, he may be more susceptible to certain approaches. In any case, educational effort could emphasize the following: (a) reference of certain types of cases to a hospital or health center (as a rule, the shaman would find it easier to refer a case to an impersonal institution rather than to an individual doctor) and among them might be suspected cases of hepatitis, food-poisoning, cataract of the eye (or possibly trachoma), and so on; (b) to give further dietary and medical advice which do not run counter to modern practice (simple hygiene and sanitation advice, for instance) and (c) to add some beneficial substance such as glucose to his magic potions (the dhami's Case No. 8 where an infant is said to be bewitched is most likely a case of malnutrition). The suggestion made here is for a program of deliberate attitudinal change among the shaman-curers aimed at their acceptance of a role ancillary and not opposed to modern medical practice.

Notes

1. The field work of Bhaskar S. Rana is gratefully acknowledged.
2. Ferdinand E. Okada; "Profiles of Selected Gaon Panchayat Areas in Nepal" (ms).



health services and some cultural factors in eastern nepal

C. J. Wake

The intent of this paper is to describe certain aspects of illnesses and of health facilities on a comparative basis between geographical regions in East Nepal. The focus will be on diseases whose remedies have implications for changes in socio-cultural conditions. The impact of health services as they presently exist will be discussed from the points of view of doctors, administrators, health workers and villagers. The data were collected in interviews and by observation in Solukhumbu, Dhankuta, Jhapa and Dhanusha districts in the months preceding the nation-wide integration of basic health services. We are not therefore so much concerned with, for instance, actual incidence of diseases in the respective areas or with statistical records of achievement so much as in experiential perception of them by people working in the field.

Following the establishment of integrated health services, considerable improvement in the nation's health is anticipated by the end of the fifth "Five-Year Plan". The project formulation for these services meticulously details the broader outlines of the national plan, which has not failed to identify any of the problems raised here. The plan is based on the policy of providing minimum health to the maximum number of people. The concept of minimum health is bounded first by the decision to use paramedical staff in health posts with more sophisticated training than health workers travelling village to village could provide, and secondly by the gradual assumption of the goals of the vertical programmes as integration evolves in delineated stages. The vertical programmes consist of malaria eradication, which has consumed annually more than half of the health department's total budget, family planning and maternity - child health care, now the unqualified priority of the plan, smallpox surveillance, tuberculosis and leprosy control. Maximum number means as many as possible within the constraints of present scarce resources and regionally balanced establishment of health posts, whose staff will include junior auxiliary health workers responsible for regulated home visits to all residents of the post's constituency. The target aimed at is one health post per 15 - 25,000 people. Changes which are expected to be most marked will be discussed here. It is hoped that this modest study of conditions in 2032 may serve as a useful record for comparison of changes by 2037.

Starting in Solukhumbu, it must be mentioned that part of this district already represents a special case compared to other mountainous areas of the kingdom owing to what is referred to there as the "miracle business" of tourism and mountaineering. However, conditions there provide interesting indications of the way behavioural and environmental modifications emerge as a result of the exploitation of economic opportunities. We take it as axiomatic that such an economic boom constitutes the single most effective

tive wedge for breaking the cycle of related factors that inhibit development in any one field. Here, only its implication with regards to health are considered.

Solukhumbu got its first permanent government doctor this year, stationed in Ansyalakarka. Because of its location at the extreme southern end of the district, its surrounding ecology and the nature of diseases there, this health post will be discussed together with the health services in the hill district of Dhankuta. The other health post in the district is in Namche, which occasionally has a resident doctor. By 2037, thirteen more health posts will have been added to the existing two and will serve approximately 106,000 residents of the district, ten of the fifteen in mountainous areas. However, as a direct result of tourism, Khumbu itself, with a resident population of just over 3,000 has at certain seasons more doctors per capita than any other part of Nepal: Kunde boasts an 11 bed hospital which the Himalayan Trust helped sponsor; the Tokyo High Altitude Research Institute and the Himalayan Rescue Association each has a doctor to cater for tourists in Pheiche but who, together with the latter's nurse in Namche, treat residents in emergencies; the Everest Hotel's doctor in Syangboche also provides emergency treatment. Finally, the new 16 bed hospital in Phaphlu in the centre of the district, built by the Himalayan Trust with local contributions of money and labour, will become a government hospital serving 20,000 people within one and a half days' walk and 60,000 within three days' walk.

Solukhumbu north of Salleri is not a special case compared to other districts solely on account of this apparent wealth of medical personnel and facilities. These endowments are qualified first by the distances over rough terrain between settlements and secondly by very limited out-reach from health posts. In Khumbu this has entailed some training of teachers as health aides for education on hygiene, dental care and the value of iodine and BCG vaccinations conducted from the hospital, as well as some antenatal care, although hospital deliveries are still rare. Rather, the area is special because initiatives and changes following the tourist boom bring in their wake autonomously generated preventive remedies to many endemic health problems. The foremost of these problems mentioned by doctors is TB which still has a higher proportional incidence there than in hill districts, in many of which a BCG programme has been underway for many years. Doctors working in Khumbu argue that poor hygiene and close living conditions contribute to its spread.

Sherpa houses are usually two story constructions built out of local stone and timber with slate roofs. Livestock is kept on the ground floor and all the family members of three or more generations live in unpartitioned space upstairs. The livestock generates heat in winter and their manure is mixed with human night-soil to be spread on fields which would be practically unproductive

without it. Small attention to insulation keeps the house well ventilated. Compared to many houses in the hills, they are free of smoke from two kinds of fireplace design. One design is the open hearth with a quadrapod for cooking vessels; the other is the enclosed stone and clay fire with two or three outlets. Bamboo brought from "down-valley" is used with grass and bracken for insulation and harbours rodents. Water storage has not been practised in the past and bathing is minimal. House design has therefore been dictated by economical use of available resources and has been in consonance with the open social relationships prevailing amongst Sherpas who, in contrast to Hindu communities, do not stress social divisions by age and sex. The implications for health have, on the one hand, been exposure to hazards that are unnecessary given the availability of new resources and techniques, and on the other, post-infantile hardiness, a high resistance to cold and a reduction of the threat of infections. (Respiratory diseases other than TB are ranked considerably lower than in hill or Terai regions). Doctors also argue that traditional child rearing practices allow for unusually neurosis-free psychic development. Overpopulation has not in the past been a problem, while nutritional surveys have concluded that a traditional diet provides sufficient calories, protein and vitamins except for the latter during some of the year.

Residents of the area say that their fields have been less productive in the last six years. Amongst the reasons for this is increasing neglect as more time is spent on catering for tourists. Similarly, tourist consumption and Namche's thriving bazar means that the area now imports a mass of grain and other foodstuffs as variegated as food to be found in Kathmandu. The assistant zonal commissioner has estimated that Rs. 300,000 is earned annually from tourism, of which Rs. 12,000 is spent on grain. Over or undergrazing is a function of the climate, so it is uncertain whether there is less livestock farming. Below 10,000 Sherpas have so quickly adopted fruit trees and vegetables that the agricultural office cannot keep pace with demand for seeds and seedlings. Indigenous consumption patterns have changed accordingly and a well-balanced diet all the year is in prospect for all inhabitants of the mountain. There is professional optimism that the frequency of peptic ulceration, ranking fourth with gastritis on the most commonly treated complaint list, may decline. The problem of iodine deficiency, second to TB in Khumbu, may subside the same way, although iodized salt supplies will need to be abetted by iodine inoculations for some time yet. One degenerate effect of new wealth and new foods has been the deterioration of teeth, but there is more sophisticated dental work to be seen in Khumbu than anywhere else in Eastern Nepal.

Modification of many features in this broad outline are now beginning to appear in the homes of the vanguard of those benefiting from the "miracle business". The observations that follow presently apply to parts of Khumbu and the main trekking route to

Namche. If it is true, as local community leaders claim, that as many now benefit from tourism as formerly benefitted from the salt trade, then these changes will be seen to extend out regardless of government initiatives. If they are not seen to, then the truth of the claim will be questionable and in matters of health, it will require all the curative and outreach facilities of coming health posts to bring outlying village health standards in line with the standards of those presently benefitting, who have the concomitant opportunity to adopt modifications that forestall the risk of some endemic illnesses.

Aside from spending on new business ventures, homes in Kathmandu, wirelesses, manufactured clothing and livestock, new wealth is going into building, of which there is a conspicuous amount. The range of what is considered economical has become vastly extended despite very high transport costs, especially of cement. The growing shortage of the suitable "biotite schist" rock and even timber, for which engineers come from as far as Okhaldhunga, will balance the deterrent factor of these costs which are likely to stay high for at least twenty years. Glass in windows (though no double-glazing yet) is common-place, as are curtains. New houses may no longer reserve the lower floor for animal use. Charcoal is beginning to be burnt for heat. There is awareness, partly engendered from the buildings constructed by the Himalayan Trust or by SATA in Jiri, of rubble foundations with trapped warm air, of more complete weather-proofing such as corrugation under the slates, of plywood for insulation and of the uses of cement: for floors instead of scarce timber and for filling cracks in the dry stone walls against rodents and draughts. Either the means or the inclination do not yet exist for adopting whole plumbing units, copper or galvanized piping, stoves, home water storage and heating units. However, most homes now use tins for food storage, many have rubber water pipes coming inside from panchayat drinking water systems. The sources of these systems are not often surveyed in collaboration with sanitation experts, but it can be said that their water is uniformly purer than that formerly tapped. This is a consideration of relatively less importance in mountain districts than hill and Terai, where abdominal diseases are more widespread. A few homes now have chimneys, often designed to filter through latrines. As the means arrive to build better insulated, weather-proof houses, so the cooking hearth becomes less essential for heat and chimneys easily adapted from the stone and clay model can be expected to spread. Even now, the latter fireplace may be more popular than the open model in areas of diminishing forest resources where careful conservation of fuel in private houses is conspicuous. This modification could reduce the incidence of eye diseases (glaucoma and conjunctivitis) as well as ear and skin diseases, respectively sixth, seventh and eighth in frequency. Doctors interviewed in the hills treat the latter more often than any other complaint. That it should occur less in the mountains of Solukhumbu where the cold inhibits bathing, can partly be ex-

plained by the cold itself. In this context it is worth mentioning a hill villager's comment on a behavioural modification of the Sherpas who have been coming down to his village market since tourism raised the demand for grain. He remarked that as tourists have increased, so has Sherpas cleanliness as they succumb to catering to foreigners' prejudices on the subject.

Injuries from accidents requiring surgery are hardly mentioned in a Khumbu doctor's casebook except for extraordinary events such as a bear attack. "Down-valley" cases of accidents to children at home while parents work in the fields are far more common. There is a peculiar number at Ansyalakarka, for example, where general injuries occur third to skin diseases and worm infections. In the Terai there is also a higher proportion of accidents, ranking seventh in one doctor's experience. This contrast may be due in part to differences in child rearing and in part to the fact that land actually cultivated above 9,000' may be less rugged than at lower altitudes. A transition to a more business-oriented economy from one based on subsistence agriculture need not of itself change child care practices, although doubts are being expressed that this transitional phase may upset the proverbial well-balanced psyche of Sherpas. Modifications in their house designs are not affecting social relations to the extent that new Western style houses in Kathmandu are upsetting the domestic convenience and order of some middle class households. The architecture may impose eating arrangements, for example, which require either an extensive range of modern conveniences or servants to be comfortable, neither of which may be available, and which confuse other family members unfamiliar with the style. The loss to Sherpas from their new house designs may be less resistance to cold, but this may be compensated by less hazards to eyes, ears and skin.

Ansyalakarka is a hill community marginally benefitting from the tourism further north. Its health post is presently understaffed and can claim only to have affected the health of bazar residents and the nearest fraction of the 80,000 people it tries to cater for in seventeen panchayats. Cases requiring surgery are referred to a hospital two days' walk away in Okhaldhunga. There, as in several district hospitals, health workers report skeptically on the condition of surgical facilities and their maintenance and supply problems.

In this area, the only environmental modification significant to health is a drinking water system. There are occasional clean up campaigns as in most bazar towns, organized by Jaycees or the panchayat. Family planning billboards and slogans have not yet penetrated this far north. Although a surplus grain-producing area, population pressure and land fragmentation into uneconomical units is becoming acute, with ensuing cases of malnutrition, especially amongst Rai families with several children close in age. Recent data from health post records reveal that this "spacing"

problem may not be as great nation-wide as was once thought. Diarrhea is the major single cause for high infant mortality rates and health staff will focus on introducing the concept and practice of rehydration in place of the popular but fatal "drying-out" treatment. This will be augmented by reemphasis on the importance of breastfeeding particularly in areas of western culture contact where unhygienic bottle feeding is apt to replace the more protein-rich milk of the mother. At present health post staff feel impotent to remedy malnutrition cases beyond dispensing vitamins. They recognize a large communication gap between themselves and villagers who fear any doctor's censorship of their child-rearing practices. The gap is often compounded by wild rumours about the effects of inoculations.

Doctors can only diagnose clinically for lack of laboratory equipment, but their curative services are for cases beyond the scope of traditional healers, jhankaris and dhamis. Nonetheless, the latter already feel their livelihoods threatened and may at present contribute to communication difficulties. A decision on incorporating jhankaris into government institutional services awaits the results of a study. Cooperation and the fostering of good relations is enjoined on all health staff in their dealings with local practitioners. There is to be a respectful interchange of information between the two with a view to ending any sense of competition. The problem of too precipitous government advances in this direction without time for a holistic education to engender more than personal gain motivations were revealed by an experiment in Nepalganj: jhankaris were invited to a few weeks' training and issued certificates, but when they returned to their villages, tended towards upsetting monopolistic practices on the strength that only they were certified by the government. The traditional relationship of the hill villager to jhankari may however help to explain less health service problems regarding payment expectation than in the Terai. There, the untrained practitioner is often more mobile and may dispense inappropriate drugs to make an impression, whereas the jhankari has a more fixed and stable relationship with his clientele who know what they are getting and know they must pay for it. This relationship is closer to that which health posts are striving to institutionalize. The Terai doctor's task is made more difficult by the need to explain a foreign system of taking prescriptions to a chemist and paying for drugs there, whereas the hill health post is often the only source of drugs.

All health staff interviewed in the Terai agreed that migrants from the hills were more health conscious than mahadeshis. Mobility correlated with innovative enterprise in other respects too, but it does not explain why they should also be more receptive to inoculations and to the stark and foreign experience of laparoscopy and vasectomy operations. The hill doctor or compounder, whose inoculation needles, for example, may be less delicate and

therefore more painful than any cossetted Western patient would expect, also meets less resistance to necessary but unpleasant treatment. Hardy upbringing must favour this reception as well as the belief that only bitter tasting medicine is effective. The ideology surrounding traditional curing fosters the concept that there is a price to pay for healing: momentary pain to overcome or offset mysterious and lingering trouble. Health services may complement the idea of atonement for illness more satisfactorily in the hills than in the Terai, but in neither is there a deeply institutionalized notion of free health service as some doctors argue. However, many communities require a baidya to conduct a puja at smallpox vaccinations. There is a possibility that this social requirement will be suitably incorporated into vaccination programmes which encounter varied social responses and therefore need flexibility. Amongst Suttars, whose social organization centres around a traditional powerful man, no programme is successful unless that leader is persuaded to take the initiative. Rajbansis do not want their infants inoculated until they are one year old and despite tactics such as primary demonstration on hill policemen, it is not unusual to see mothers bringing their children to hospitals after the inoculating team and supplies have moved on. Integrated services will assure more thorough follow-up after the initial campaign has produced the acceptance gestation period. Social organization will be especially complemented by the new plan for midwife services. As has been mentioned, even where hospitals have been established for several years, doctors and trained midwives may only handle deliveries with complications. In the Terai, experienced women of the sweeper caste (sudhinis) attend births. They and similar women in other areas will be sought out to be given supplementary training and a special relationship with health posts.

Hospital doctors now feel they have good relations with baidyas in the Terai and point out that itinerant quack doctors may serve to spread word about health facilities. There is reason to doubt this function. In one village in Jhapa regularly visited by a chandchi, a forty year old man had been wasting away for two years from stomach trouble. Bhadrapur hospital, a morning's walk distant by fair weather vehicle road, was unknown, while a small dispensary three hours' walk away was identified as the hospital. Villagers elsewhere had lost interest in hospital services because they were unable to negotiate the administrative side of admission to the doctor despite three or four successive visits. A chandchi is a man who has learnt his skills from his father. The other kind of unqualified practitioner is somebody with a few months' experience in a health post who sells drugs and vaccines. They both may provide quick relief for symptoms, acquiring a reputation and business, but their patients develop resistance to those drugs that doctors might administer on the basis of a diagnosis. The law now prohibits unauthorized sale of drugs in Nepal, but there is weak enforcement of drug controls across the border. These

practices have not moved to hill areas where, by contrast, doctors may only get patients with illnesses in late stages plus complications. An expensive drug is then needed where a weaker would have been effective earlier, particularly since most patients have not formerly been exposed to any drug. Present competition with local healers in the hills is less dangerous than in the Terai, although it too has complications which improved communications can resolve.

The southern end of Solukhumbu, like most of Khotang and many other places in Nepal, is more isolated at this stage of development than other geographically remote parts of the country such as Khumbu. Health there in the long run is dependent on the success of more directly productive programmes, (industries associated with fruit and sheep for instance) and on transport. Location of health posts in the next five years recognizes this special criterion of remoteness. As a service, health facilities do not have to agglomerate around growth centres.

Dhankuta bazar is a growth centre with one of the oldest hospitals in the country. There are now five health posts and three family planning clinics. Four more are scheduled so that nine will be serving a population of about 130,000 in thirty-eight panchayats. In villages where a clinic already exists, there were hopes for expanded facilities, whereas a health post is seldom mentioned amongst the needs of those villages where none is yet established. This phenomenon of the supply preceding awareness and demand is more pronounced in the Terai. Every health facility in the district is understaffed which is a problem dependent in the Institute of Medicine's training programme. Training and staffing is complicated by trainees' ambitions to become doctors as soon as possible, leaving gaps at the intermediate levels of service. Minor surgery can be performed at the 15 bed hospital, but compared to the Terai, it is not burdened by more patients than facilities nor by a drug supply problem. Regardless of demand, all 15 bed hospitals are issued the same amount of drugs. Government facilities are supplemented in this area by other agencies such as the Britain Nepal Medical Trust's hill drug scheme, clinics provided by agricultural stations, Gurkha pensioner welfare offices, and tea estates and industries, of which there are more of course in the Terai. TB clinics here have now reached the stage where a specialist doctor is redundant for curative work. A laboratory assistant can perform all necessary duties and still be underworked.

It is only in bazars, however, that health consciousness exist and where building designs are being modified. Tiles are practically no longer being made in Dhankuta, but are being replaced by more weather-proof corrugation. Elsewhere, the shortage of wood, two days' supply of which may require a day to collect, is critical and respiratory diseases are second only to skin and abdominal complaints in number. Increasing numbers of panchayats

are getting water systems, but no village in this district or in Dhanusha provided an exception to the rule that the most valuable land is that closest to homes; in other words that land best fertilized by humans living in close proximity to livestock. (Jhapa was exceptional because much land is newly deforested.) The courtyards and interiors of most Brahmin, Chhetri, Rai and Limbu homes are kept immaculately clean. No authority interviewed was definitive on whether cleaning techniques are hygienically sound but hypothetically, abdominal problems would occur less often amongst these four groups than, for example, amongst many Magar, Thami, Kami or some Maithali castes who give less attention to house cleaning. In Jhapa, one doctor thought that thirty per cent of his cases were abdominal problems. It is noticeable there how quickly some drinking water wells have deteriorated for lack of protection, but new systems are rapidly increasing. Cement houses stand out there because every village boasts one or two, while the rest are constructed either of wood and tile or of mud and straw, neither of which are fully rodent or weather-proof. Associated with this is the estimate that twenty per cent of doctor's cases were respiratory in nature. Corrugation is not used because it causes unbearable heat in summer. A Terai house requires new thatch every two or three years, compared to ten or twelve in the hills. Given transport facilities and economic opportunities, the hill ecology would appear to be more favourable for architectural health protection measures than the Terai ecology.

Family planning workers admit to a very slow start in Dhankuta. Now there is increasing response following door-to-door visiting, pre and post-pregnancy examinations, radio education programmes and protein and vitamin handouts to mothers. Workers' experience underscores the correlation between education and acceptance, Limbu communities lagging in this regard. The popular perception of children is to see them as the only possible luxuries in a couple's life, as well as necessary for their economic contribution. This is likely to prevail until money-making opportunities other than unappealing employment in Terai industries appear, or subsistence farming can develop into business ventures. In the Terai, births are often thought to be subject to God's will alone. Amongst Rajbansis family planning measures are offensive to ancestors. A change to the more pragmatic attitudes of hill people may depend on how successfully the infant mortality rate can be reduced. Family planning workers in Dhanusha hold that its high rate reduces their credibility and the programme's effectiveness.

Flexible eating habits amongst Rais and Limbus have persuaded health staff that the district, although presently a grain deficit area, has a low incidence of malnutrition. There are anomalies such as occasional scurvy despite a vast surplus of fruit. This is a question of taste and consumption habits rather than taboo. Some Rais will not eat lentils with maize or millet porridge, but taboos like this can have little effect on nutrition standards.

Protein consumption is high compared to the Terai where milk products and goat may be the only, but expensive, form of it consumed. Correspondingly, illness associated with deficiency are reckoned to account for 50% of a doctor's cases in Jhapa and as much as 75% of another's in Dhanusha. Tharus are seldom treated for malnutrition because their fishermen regularly distribute their day's catch to their section of a Tharu village. There is optimism that fish consumption is becoming more pervasive, but its spread as well as that of other development crops to the most needy may yet take time. In Jhapa, the agricultural office calculated that its extension efforts have reached barely 5% of the district's farmers so far. The health department is concentrating on supplementary foods for infants, recognizing that the Nepali population as a whole is more flexible about eating habits than may once have been thought. For instance, black dahl, which is unpopular in India, is more easily grown than other varieties in hills and so its consumption is held to be more suitable for cold climates.

Malnutrition is the problem par excellence of poverty, enmeshed in a network of economic and population factors, each object to its own cyclical delimitations. Forty-two per cent of Dhanusha's population is under fourteen years old, which means there is a high proportion of family members unable to take part in primary productive work. In some families the ratio of productive to non-productive members is lower than two to ten. Gastroenteritis and hookworm head the list of specific abdominal illnesses, both of which lead to anaemia and then to malnutrition and so into the cycle of less agricultural or other productivity, and higher fertility to compensate.

There is presently a corps of sanitation workers who believe that health education can be the only effective wedge into this cumulative cycle, and so reduce a typical Terai doctor's work-load from over two hundred patients in five hours to manageable limits. Most of these sanitation workers now work on vaccination programmes or have switched to other jobs. The causes of their dissatisfactions and frustrations are three fold. Up till now only a miniscule proportion of the health budget has gone specifically into public health programmes. Doctors themselves are not supportive of such spending and collectively have sufficient weight to see that their own priorities take precedence over field-oriented work and the creation of dynamic rather than mechanically functioning village health posts. Typically, sanitarians point out that it is doctors who are invited to advise a nagar panchayat on public latrines, which do not get built or maintained to the minimum standard that a field expert would impose. Doctors in fact have a peculiarly powerful relationship to villagers too. Whereas other government offices may be subject to complaints, often on spurious or inter-necine grounds, the peasant farmer has no sense of a right to a doctor's service. The doctor can always fall back on private practice, although some argue that if their salaries were increased for government service they would be happy to be free of the greater

demands on their time in private. Thirdly, they perceive small promotion opportunities and small recognition of their training and its value. However, from this year 70% of the approved budget will be devoted to preventive programmes (including malaria eradication) with public health inspectors in every district.

Unfortunately the preventive measures that health education would lead to are often too expensive to be adopted by these who recognize their value. This applies to shoes and private stores of bandages and disinfectant to treat cuts, both of which would protect against hookworms. Even panchayats, which are beginning to protect water sources have no resources to deal with health hazards like flies. Protection against them would require capital outlay to adopt new techniques for preserving, drying and cooking foods, apart from radical changes in waste disposal. It is arguable that defecation habits are a cultural manifestation of the supremacy of religious ideas, not a matter of material contingency. The design and use of sanitary latrines would need to be planned accordingly, with more options than simply ladies and gentlemen. Drinking boiled and therefore safe water and washing food in boiled water, on the other hand, is an economic question dependent on the availability of cheap fuel. In the long run the issue can be circumvented by concentrating on safe water supplies. More compost pits for animal wastes are to be seen in the hills than in the Terai at present, but the use of soap for washing is spreading faster in the latter. This may partly explain why skin diseases like scabies and pyoderma rank higher in the hills. They also occur more frequently in Dhanusha than Jhapa, perhaps on account of the existence of more ponds in the former. Static ponds are a medium in which skin diseases can spread to all who bathe in them. Although it is preferred that drinking water comes from a flowing source, this does not apply to bathing water.

This paper has given the impression that conditions of health are worse in the Terai than in the hills and mountains. This may or may not be the case. The impression is gained partly as a consequence of the fact that there are more modern health services in the Terai. There is therefore more awareness of local health problems as well as increasing use of facilities by local people. Jhapa has an expanding twenty-five bed hospital, two ayurvedic and eight other health posts and five family planning clinics, serving over 250,000 people in forty-four panchayats. Two more posts are scheduled by 2037. However, there now exists a treatment vacuum whose causes are deeper than the supply or non-supply of health posts and raise the fundamental issue of developing health posts in consonance with socio-cultural conditions. It can be illustrated by the experience of Red Cross staff in Jhapa. Their duties include the distribution of food which may for example be sold by parents instead of being given to their babies. Small handouts lead to expectations that the government supply everything free; staff begin to feel exploited and tempted to use coercion in place

of persuasion. These inflated and unrealistic expectations are symptomatic of a transition in villagers' world-view towards an inadequately assimilated one that incorporates faith in the scientific rationality upon which modern health facilities have been based. They are likely to persist until the people who staff them make two concessions: first, that traditional treatment and the world view that sustains it, about which they are inclined to be so deprecatory, have their own rationality and are satisfying in as much as there is no gap between delivery and expectation; and secondly, that modern medicine itself has limitations, its history of discovery notwithstanding. It is understanding of its limitations that fosters a healthy relationship between a system and those who benefit from it. Without this reciprocal understanding, health posts themselves may act like foreign bodies in the social organism, actually engendering sickness while forcing individuals to undergo a long and painful transition period in order to assimilate them.

Dhanusha has an expanding twenty-five bed hospital, seven health posts and six family planning clinics for a population of over 330,000 in 104 panchayats. Doctors face problems of bed, staff, transport and equipment shortages and sometimes language difficulties. One outcome of staffing shortage, also to be found in Jhapa, is that an auxiliary nurse midwife may never be able to be "off-duty". Despite the provision of lodging, she may find it hard to live on her salary of Rs. 200 per month. Supply, supervision and functioning of health posts are still felt to be inadequate and unable to meet villagers' expectations. Transport is relatively good in the district and by 2037 no villager will need to go more than six miles to a health post. Walking conditions in the monsoon are especially difficult for women. However, there is still inter-village politicking about health post locations. Health aides are often absent and a single misfortune such as a supervised still-birth costing a family Rs. 250 or private dealing in drugs can damage future initiatives from a health post.

These are amongst the problems that the new health plan is tackling during the next five years. It will bring more regional balance of services and more uniform, decentralized administration. There is a major effort to find compatibility between traditional practices and procedures advocated in modern text-books. For example, there will be no effort to alter the usage of post-natal isolation for mothers and babies whose benefits in present conditions outweigh text-book critique.² One of every health posts' two auxiliary workers will be charged with preventive duties, aided by six preventive field workers carrying iodine tincture, rehydration packets and vitamins during home visits. They are provided with daily and travel allowances and sleeping gear, lack of which has inhibited enterprise in the past. Disease does not strike rich and poor equally, but these perks will help to assure that their visits will not be dictated by the human factor of ex-

tending services primarily to those who can provide meals. Their experience will provide more specific data on local health practice and their consonance with modern methods. The health plan's strategy is in part based on awareness that the incidence of most diseases is associated with socio-cultural factors. The success of those vertical programmes that are not related with these factors is still dependent on taking account of them. Health services are in a state of transition from a situation where curative facilities have just been sufficient to prevent an irriversibly downward trend. There is an analogy in health service development to the search for a solution to the spread of the banmara weed: chemical and biological control has been tried with "curative" insecticides and natural predators. These may now be supplemented by cultural control employing mass compost campaigns.

FOOTNOTES

1. I would like to express my thanks and indebtedness to all the people with whom I talked during this time, too many to list by name.
2. Dr. Rita Thapa, untitled paper presented to Seminar on Medical Education Suitable for Developing Countries, Kathmandu, Nepal, 1975.

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